Baptist Community Ministries

The Value of Investing in Federally Qualified Community Health Centers

CAPITAL LINK

Prepared by Capital Link, Inc.

BCM

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Introduction Background

About Baptist Community Ministries

Baptist Community Ministries (BCM) is a health conversion foundation with a mission of "improving the physical, mental, spiritual, and social lives of people living in the greater New Orleans region." Founded in 1924 from the sale of two hospitals, BCM serves five Louisiana counties, or parishes: Jefferson, Orleans, Plaquemines, St. Bernard, and St. Tammany Parishes. Today, BCM focuses its grant support in four strategic areas, or zones: health, education, public safety, and governmental oversight.

Hurricane Katrina as a Galvanizing Event

BCM's long-standing commitment to health care deepened after Hurricane Katrina struck the region in August of 2005. The hurricane destroyed much of region's infrastructure in Greater New Orleans, including the health care delivery system. Existing issues of poverty, high rates of uninsured working poor, untreated chronic diseases, and lack of access to neighborhood primary care services were dramatically exacerbated by the storm. In the aftermath, the immediate demand for primary and mental health care quickly overwhelmed available resources. Inappropriate and expensive utilization of the emergency room increased, stressing the already inadequate primary care infrastructure serving low-income residents.

After the hurricane, a wide range of leaders in health policy and healthcare organizations—including public, private, philanthropic, and safety net clinics—joined together to develop a strategy to redesign the healthcare infrastructure in the region. This quickly-articulated plan realigned the locus of primary care to focus on neighborhood health clinics rather than relying solely on Charity Hospital. This plan was endorsed and subsequently funded by federal officials in the Department of Health and Human Services. A key element of the redesign was the expansion and transformation of existing safety net clinics into medical homes that would provide multi-disciplinary, team-based care. In July 2007, Louisiana received a three-year, $100 million Primary Care Access and Stabilization Grant (PCASG) to restore and expand access to primary medical care, behavioral health, and dental care services in the greater New Orleans area. Twenty-five outpatient provider organizations in Greater New Orleans, including St. Thomas Community Health Center and Access Health Louisiana, received PCASG funds.

Federally Qualified Health Centers as a Strategy for Sustainable Primary Care Delivery

Through its work in developing a regional primary care investment strategy, BCM identified that federal funds could be leveraged to expand primary care services for low-income uninsured and underserved residents via creation of new Federally Qualified Health Centers (FQHCs) throughout New Orleans. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act. FQHCs qualify for enhanced, cost-based reimbursement from Medicaid (based on the Benefits Improvement and Protection Act/Prospective Payment System Act) and also now Medicare. In addition, FQHCs receive other benefits like annual operating grants, legal protection

under the Federal Tort Claims Act, and discounted drug pricing through the 340B Drug Pricing Program. Health centers that gain FQHC status also receive an annual grant starting at $650,000 that helps subsidize crucial wrap-around services like case management and education, and defray the cost of delivering care to patients without insurance. FQHCs must serve a federally-designated underserved area or population (called a Medically Underserved Area or Population), offer services on a sliding fee scale with respect to income, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors on which patients of the health center comprise at least 51% of members. An intermediate step for FQHC status is certification for FQHC "Look-Alike" status, which allows for enhanced reimbursement but does not provide an annual operating grant.

Though becoming an FQHC is an arduous task for primary care clinics, BCM staff recognized that securing FQHC funding was a long-term solution to financial viability for any potential clinical partner serving under- and uninsured residents. In 2007, BCM commissioned an environmental scan of Orleans Parish to identify the number of FQHC clinics that could be supported if federal funds became available. Results of the scan indicated that funding would support up to three or four entities with 12 satellite FQHC clinics.

BCM therefore made the decision to focus its primary care investment strategy efforts on assisting two local clinics in becoming certified as FQHCs: St. Thomas Community Health Center (STCHC) and Access Health Louisiana (AHL). This proactive, multi-year investment to provide robust technical assistance, as well as critical operating support, represented a risk not typically taken by BCM. However, BCM staff knew that if successful, the ongoing federal funding and enhanced reimbursements would make these FQHC clinics self-sustaining into the future. Because of the challenging nature of achieving FQHC status, BCM prioritized the following activities: finding the right partners, providing resources for consultant assistance, and overseeing the FQHC application process to ensure success.

Purpose and Methodology

The purpose of this report is to demonstrate the impact of BCM's investment in both STCHC and AHL over the funding period of 2007 to 2014. Capital Link, a nonprofit technical assistance organization with over 15 years of experience evaluating the economic impact and financial and operational performance of FQHCs, was hired by BCM to prove an objective third-party analysis of STCHC, AHL, and BCM's investment in these two organizations. Capital Link studied each health center's service area, operational data from the Uniform Data System (UDS), and financial data via audited financial statements. Due to the availability of operational data, patient and visit statistics were analyzed between 2009 and 2014, while financial data was evaluated for the full 2007 to 2014 period.

The following is a history of how strategic BCM investments were leveraged to help establish and sustain access to primary care for low-income residents in Greater New Orleans. Community, financial, and economic impact will be addressed.

St. Thomas Community Health Center
History of Funding

About the Organization

Founded as St. Thomas Community Health Services in 1987, St. Thomas Community Health Center (STCHC) provides essential, comprehensive primary health care services to the medically underserved and vulnerable populations residing in and around the redeveloped St. Thomas Housing Project in New Orleans, as well as the greater New Orleans area (both the east and west banks of the Mississippi River). With key technical assistance from BCM, the health center first became an FQHC Look-Alike provider and subsequently became a fully-funded Section 330 Federally Qualified Health Center (FQHC) in 2009. Today, STCHC provides over 32,000 medical, behavioral health, and vision services visits to nearly 12,000 patients. BCM's sustained multi-year strategic grant funding to STCHC has supported the financial and strategic planning, as well as the technical support that was necessary to achieve FQHC status. Becoming an FQHC has allowed STCHC greater financial stability as well as expansion of services to multiple locations, resulting in deepening and broadening its services to the community.

Funding History

Prior to Hurricane Katrina, BCM was aware of STCHC's long history of service to the poor, making the health center a natural partner in 2007, when BCM commissioned an Environmental Scan of Orleans Parish. The goal of the comprehensive was to identify opportunities for development and expansion of sustainable primary care services for low-income uninsured and underserved residents. BCM formulated a plan to determine whether federal funds could be leveraged to expand primary care via creation of new FQHCs throughout New Orleans. This would expand options for primary care into additional neighborhood locations. Given the unprecedented investment in regional primary care by the federal government and anticipated ongoing federal support, STCHC was selected and evaluated for its capacity to grow in the post-Katrina funding environment; this strategy also capitalized on the market presence STCHC already had built in the St. Thomas neighborhood. Initial analysis revealed that long-term stability would be greatly enhanced if FQHC status, its attendant stabilizing financial grants, and other related benefits could be obtained.

BCM's strategic grant and technical assistance support allowed STCHC to obtain FQHC Look-A-Like status in 2008, allowing for STCHC to receive cost-based reimbursement, thereby boosting Medicare and Medicaid revenue. By 2009 the health center received full federal funding as a Section 330 health center (FQHC), again aided by BCM with technical assistance and grant support.

As STCHC's revenue began to stabilize, the clinic grew. Prenatal and post-partum obstetrical services were added in January 2010. In August of that same year, a new pediatric clinic in the Mahalia Jackson Child Learning Center was opened. BCM transom funding (the foundation's term

for one-time, program-specific funding) assisted with the expansion into this economically depressed neighborhood, which provided much needed pediatric care to some of the city's poorest children. Additional BCM transom grant resources were provided to develop an information technology infrastructure and expand mental/behavioral health services to a new location in partnership with Trinity Counseling and Training Center. In 2013, a third satellite location at Columbia Parc was launched. This expanded much needed services to a new mixed-income community, which replaced a former housing project in a severely economically distressed neighborhood. Today Columbia Parc residents enjoy primary, obstetrical, and dental services. BCM support is currently assisting STCHC as it expands pediatric outreach and service coordination in an effort to identify health and developmental issues early on.

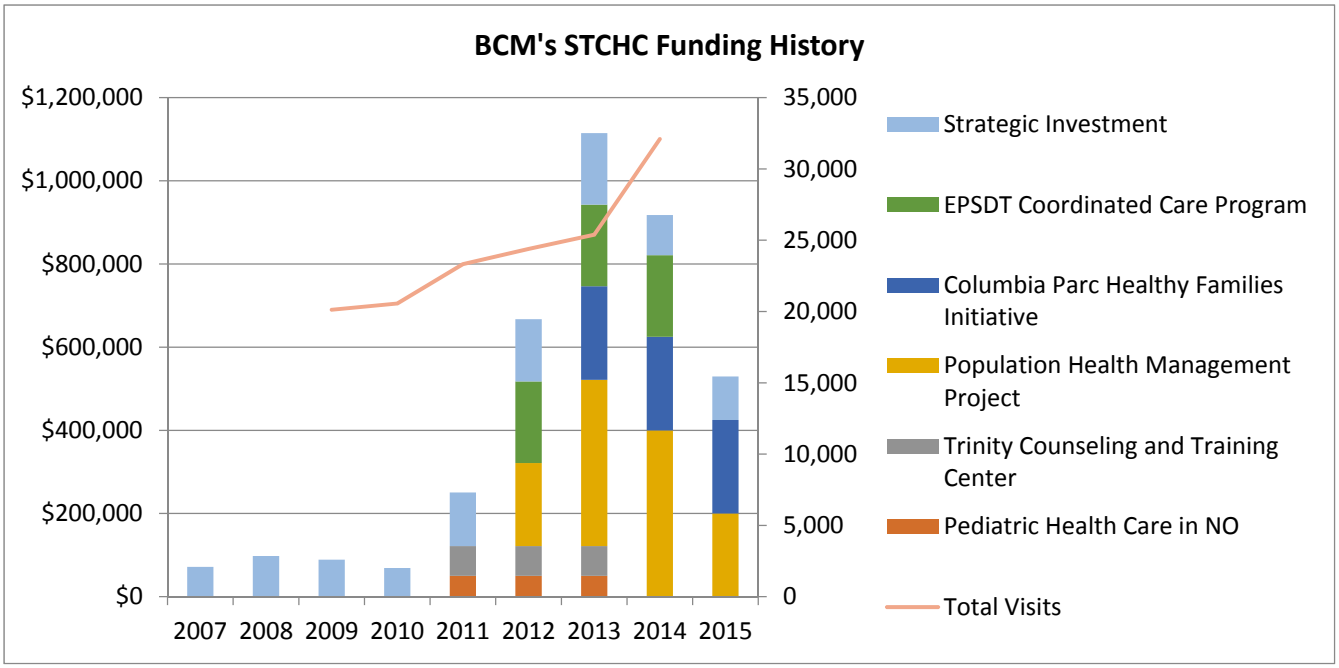
Summary of Key BCM Grant Investments

As the BCM/STCHC partnership evolved, the need for additional funds to leverage federal, state, and local funding opportunities became apparent. Transom grants were utilized to support specific STCHC developmental opportunities designed to expand pediatric service, develop infrastructure to support quality improvement initiatives and create partnerships for mental health services. The transom grants are briefly summarized below.

Key BCM Grant Investments in STCHC

- **Pediatric Healthcare Services in New Orleans, LA:** In February 2011, an award of $150,000 was provided to establish pediatric services to the Mahalia Jackson Preschool population and surrounding pediatric community. Co-located in a community resource center with the school, this facility serves one of the most economically and resource depressed areas of the City.
- **Strategic Direction and Assessment for the Trinity Counseling and Training Center (TCTC):** In April of 2012, BCM provided funding to TCTC in the amount of $220,000 to evaluate the feasibility and financial viability of a formal partnership with STCHC for the provision of basic mental health services. This grant paved the way for a future referral relationships implemented in 2014.
- **STCHC Population Management System Project:** STCHC achieved Patient Centered Medical Home (PCMH) status as recognition by the National Committee for Quality Assurance. Development of chronic disease management systems within the newly implemented electronic medical record system was underwritten with an $800,000 grant in August 2012.
- **Columbia Parc Healthy Families Initiative:** In July 2013, this $675,000 grant supported satellite clinic development at the site of the former St. Bernard Housing Project. This location expanded primary care services, and implemented obstetrical services in partnership with the March of Dimes and the Louisiana State University Health Sciences Center, in collaboration with the Bayou District Foundation.
- **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Coordinated Care Program:** In February of 2015, BCM provided $588,189 for operational support to implement the EPSDT Coordinated Care Program at Mahalia Jackson. This Medicaid program is designed to discover, as early as possible, the ills that handicap low-income children and to ensure that they receive the appropriate preventive, dental, mental health, developmental, and specialty services.

The chart below illustrates all investments in STCHC made by BCM, including ongoing strategic funding as well as the five transom grants described above. Of particular note is that the year with the greatest investment by BCM, 2013, was followed by a significant 26% increase in patient visits to 32,000 per year. BCM awarded STCHC a total of $2.83 million in transom funding and $587,850 in strategic support between 2007 and June of 2015, all of which have helped build STCHC into a more robust FQHC network as it prepared for health reform implementation.

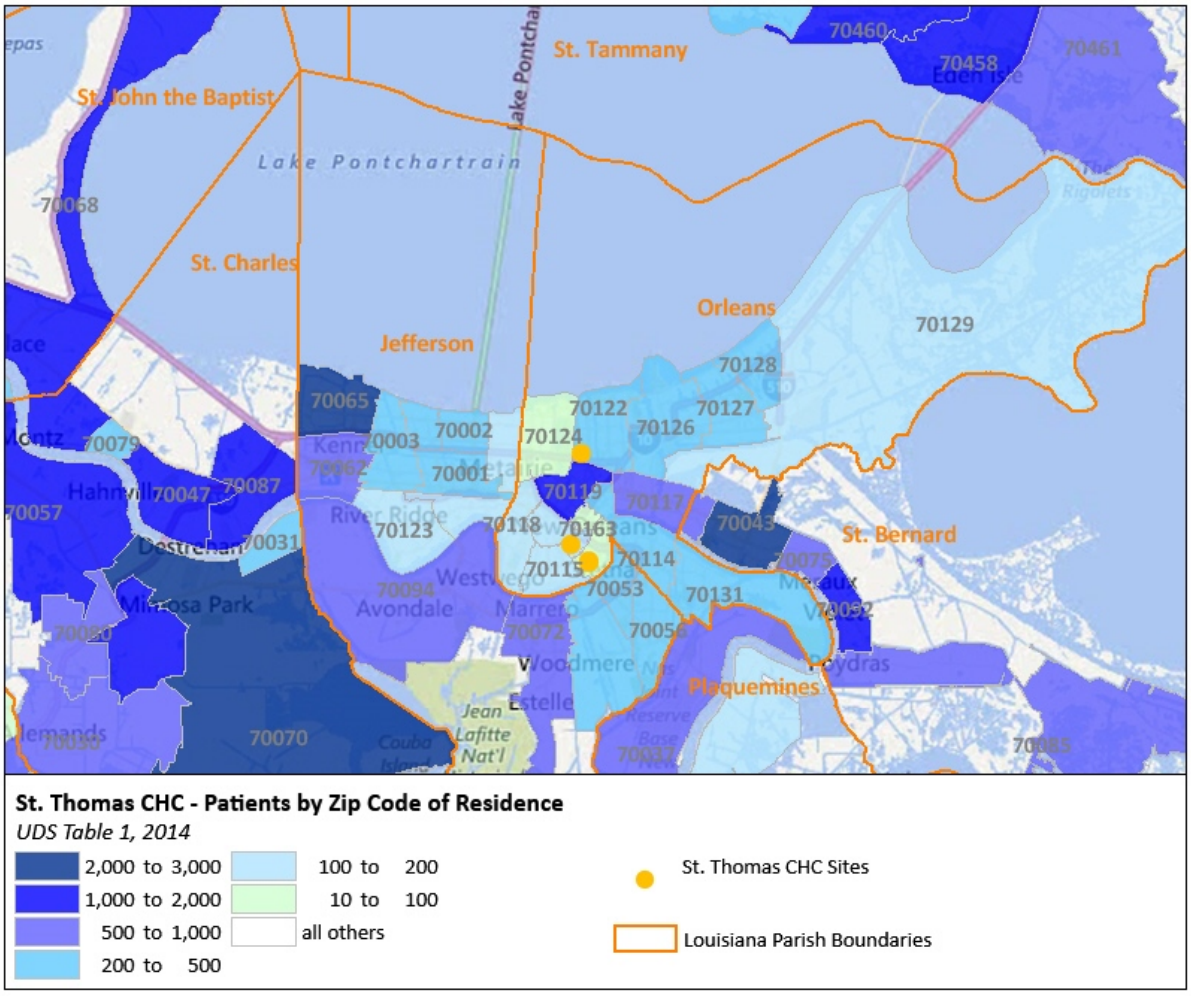


The three sections that follow summarize the community, financial, and economic impact of BCM's investments in STCHC. Although notable growth was fueled prior to 2009, for the purposes of this report, patient impact and economic impact analysis of the health center will be limited to the period of time between 2009 and 2014, during which the health center was certified as an FQHC and was required to submit detailed patient data to the Health Resources and Services Administration (HRSA) in the form of UDS reports. Because financial data was available earlier, the financial impact section of this report utilizes data for the years 2007 through 2014.

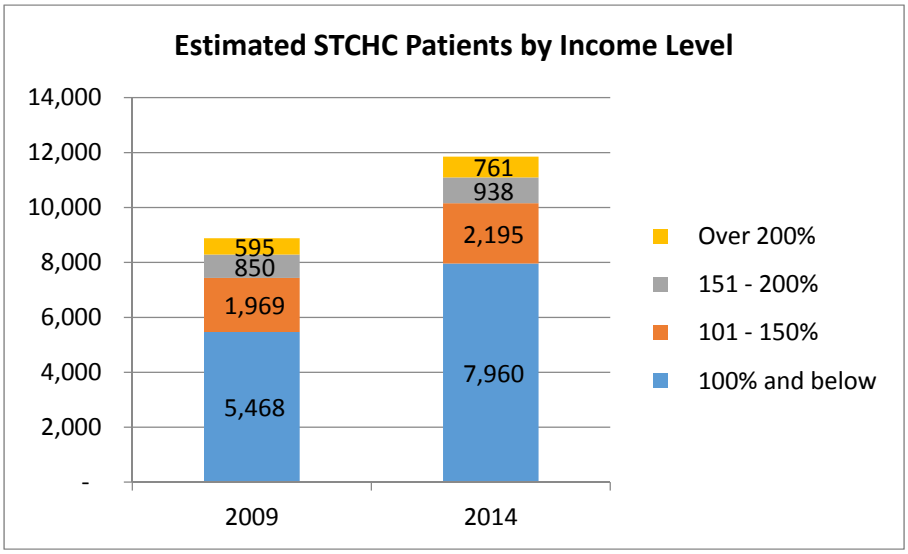
STCHC Market Trends and Community Impact

Over the 2009 to 2014 review period, STCHC has demonstrated an increased presence across multiple parishes with respect to unduplicated new patients, reaching 3,000 more patients annually in 2014 than it did in 2009. Today, the health center sees nearly 12,000 patients each year at over 32,000 annual medical, behavioral health, and supportive enabling services visits.

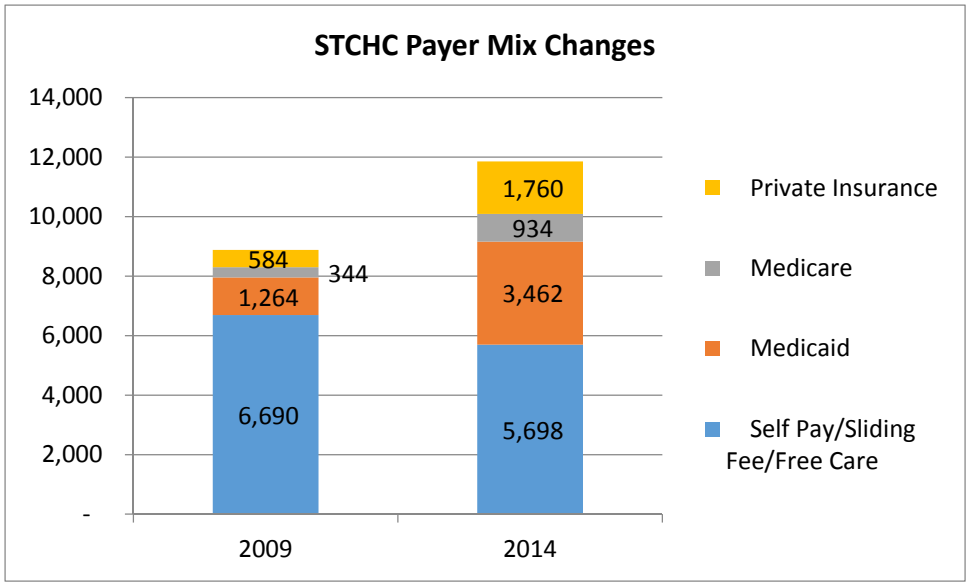
Since STCHC became an FQHC in 2009, the health center has been required to provide patient data, including by zip code of residence, to HRSA in the form of its annual UDS report. The map below utilizes STCHC's 2014 patient by zip code data and indicates the breadth and depth of STCHC's presence in the community. It is clear that the health center has a broad reach, with thousands of patients coming from zip codes across all of the BCM parishes of interest—Jefferson, Orleans, Plaquemines, St. Tammany, and St. Bernard—even though it is located only within Orleans Parish.



The charts below provide perspective on the shift in patients by income and insurance type between 2009 and 2014. Over the six-year review period, STCHC served nearly 2,500 additional individuals at or below the poverty level, as well as a modest increase of those between 100% and 200% of the poverty level.

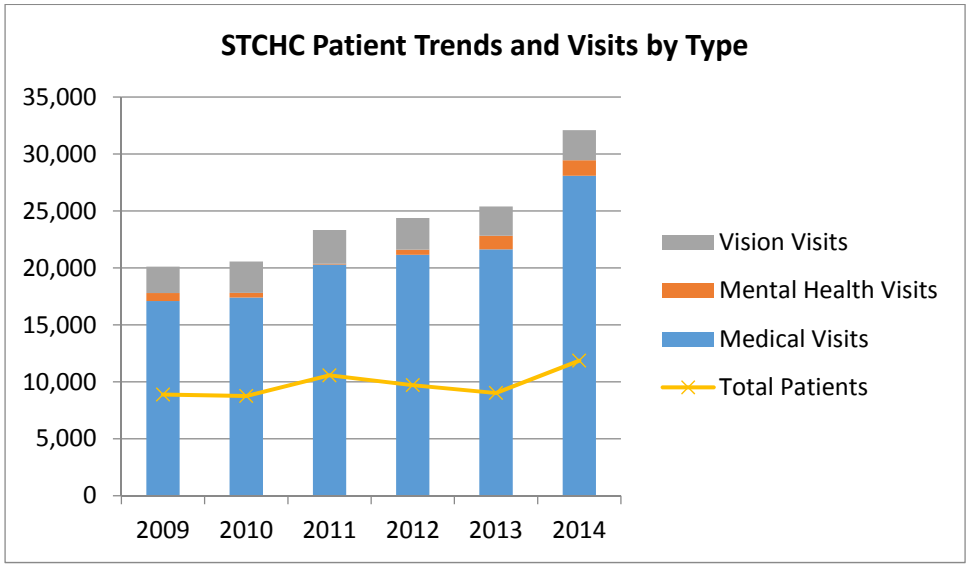


STCHC also experienced a large shift in its payer mix, or mix of insurance types. Over the review period, STCHC gained 2,200 patients insured by Medicaid, which is by far the best payer type for FQHCs due to cost-based reimbursement. This increase in Medicaid patients occurred as the number of uninsured patients decreased due in part to STCHC's investment in enabling services, which include enrollment assistance. Other changes in the payer mix include an increase of 600 Medicare-insured patients and nearly 1,200 new privately-insured patients.



The increase in Medicaid-enrolled patients is also due to a change in eligibility for the program that was established in October of 2010. At that time, the original federal grant to establish and expand primary care (PCASG) was transitioned into a new grant, the Greater New Orleans Community Health Connection Program (GNOCHC). This program is a Medicaid 1115a Demonstration Waiver designed to provide primary, preventive, and behavioral health services to area citizens ages 19-64 who do not typically qualify for Louisiana's stringent Medicaid enrollment criteria but whose income places them at or below 105% federal poverty level (FPL). It is available to residents in the greater New Orleans regions of Jefferson, Orleans, Plaquemines, and St. Bernard parishes. This federal waiver allowed many individuals now established in the primary care network to secure insurance coverage for the first time and continue uninterrupted care. Although the reimbursement levels were less generous than the original federal grant, ongoing Medicaid reimbursement was essential to the financial health of the primary care providers. Because Louisiana did not expand Medicaid eligibility under the Affordable Care Act (ACA), the future funding of this program is unclear. If the waiver is not legislatively renewed in 2016 or if Louisiana elects not to implement the ACA with its attendant Medicaid coverage for low income residents, STCHC stands to lose a valuable revenue stream as much of its patient base will revert from cost-based Medicaid coverage to once again being uninsured (i.e., self-pay).

The chart below illustrates the increase in annual visits from 2009 to 2014. Over the review period, STCHC provided a total of nearly 146,000 patient visits. Most notable is that total patient visits grew by 26% in just one year, 2013 to 2014, the same year that BCM investment in STCHC was at its height, with all five STCHC funding programs active.



Also of note is that mental/behavioral health visits nearly doubled between 2009 and 2014. Additionally, the increase between 2011 and 2013, which continued in 2014, coincides with funding from BCM for the partnership with Trinity Counseling and Training Center. This partnership allowed for the creation of an expanded behavioral health services program.

STCHC Financial Trends and Impact

While operational (UDS) data was only available beginning in 2009, financial data was available for STCHC as early as 2007, which marks the beginning of BCM's major investments in this health center. Therefore, Capital Link was able to study STCHC's audits for the fiscal years ending December 31st, 2007 through December 31st, 2014 (FY07 through FY14). The table below summarizes the eight-year trends and FY14 results, and is followed by a discussion of key financial strengths and challenges.

STCHC Financial Trends - FY07 through FY14

Revenue and Expense Composition	Target	FY 14	Eight-Year Average
Operating Margin	> 1-3%	1.0%	-12.8%
Bottom Line Margin	> 3%	1.0%	4.6%
Personnel Related as Percentage of Operating Revenue	< 70-75%	79.1%	86.7%
Operating Revenue Growth Rate		-9.0%	26.2%
NPSR Growth Rate		-15.1%	217.6%
GCR Growth Rate		16.0%	297.8%
Operating Expense Growth Rate		1.3%	13.8%
Revenue Mix {NPSR}		47.1%	39.2%
Revenue Mix {GCR}		34.6%	42.9%

Liquidity	Target	FY 14	Eight-Year Average
Days Cash on Hand	> 30-45 Days	64 Days	81 Days
Current Ratio	> 1.25	14.0	8.0
Days Net Patient Receivables	< 60-75 Days	45 Days	83 Days
Days in All Receivables	< 60-75 Days	26 Days	36 Days
Days in Accounts Payable	< 60 Days	16 Days	35 Days
Working Capital Growth Rate		400.2%	-23.3%

UDS Measures	Target	FY 14	Six-Year Average
Patient Visits		32,099	24,314
Patient Growth Rate		31.4%	7.1%
Operating Revenue Per Patient		$682	$707
Operating Expense Per Patient		$675	$703

Financial Strengths

On the statement of activities, total operating revenue and total operating expenses each grew by 160% over the review period, for an annual average growth of an impressive 22 percent. This represents a major shift in the profile of this organization, as an organization with an $8.1 million budget (as of FY14) requires greater coordination and sophistication than an organization with a $3.3 million budget (as of FY07). Finally, net patient service revenue (NPSR) increased as a proportion of total operating revenue by nine percentage points (from 38% in FY07 to 47% in

FY14, peaking at 65% in FY12). This indicates a reduced reliance on grant funding as the health center builds its patient revenues.

On the balance sheet, STCHC's level of days cash on hand is well above the recommended range of at least 30-45 days cash on hand and averages 64 days cash on hand for the review period, indicating ample cash reserves in most years to weather fluctuations in cash inflows that health centers occasionally experience. This measure was below the recommended benchmark for two years (FY12 and FY13) but recovered in FY14 to reach 81 days. STCHC also has a very low rate of Days in Accounts Payable (which was well-below Capital Link's recommended maximum of 60 days in all but two years, FY11 and FY07), indicating a strong ability of the health center to pay bills as they come due. The health center is also successful in its billing and collections policies and procedures, with Days in Net Patient Receivables at or below the recommended range of 65 to 75 days in all years but FY08 and FY10.

Financial Challenges

On the statement of activities, while operating revenues and expenses grew at nearly identical rates over the full review period, this growth was uneven and, in some years, resulted in large negative operating margins (in FY08, FY11, and FY12). The large negative margins in FY11 and FY12 are related to the capital project completed in FY11 (when $4.9 million in fixed assets hit the balance sheet); most health centers experience negative operating results in the first year to two years after opening the doors of a new facility. Large negative operations in FY12 were related to a large ramp-up of staff (for which salaries grew by 34% from FY11 to FY12), which was not rewarded until FY13 when NPSR increased by 34% from FY12 to FY13. Capital Link has observed that this one-year lag between an increase in staffing expenses and NPSR is typical for health centers completing capital projects.

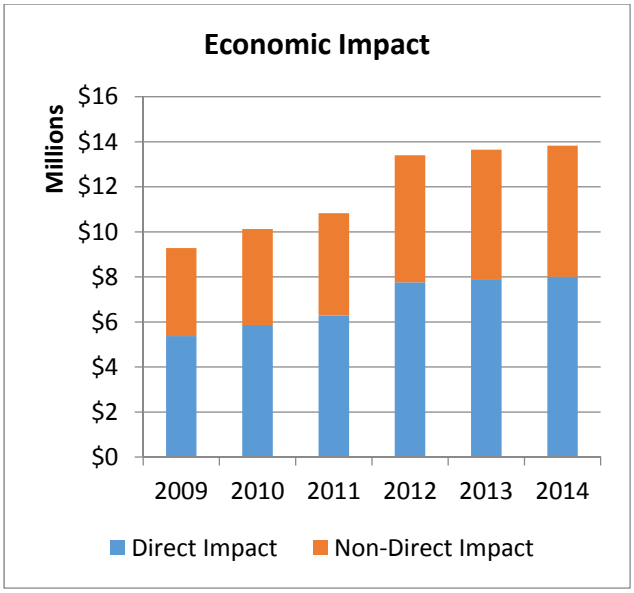
On the balance sheet, STCHC reported one year of negative net assets in FY12. This is related to a difficult operating year as discussed in the next paragraph, wherein the health center was experiencing growing pains as it adjusted to a newly opened facility and ramped-up its staffing levels. This negative net worth resulted in negative leverage (total liabilities divided by total net assets) just in FY12, but this measure was within recommended ranges in most years, with leverage at 1.5 as of FY14 (the recommended maximum is 3.0.

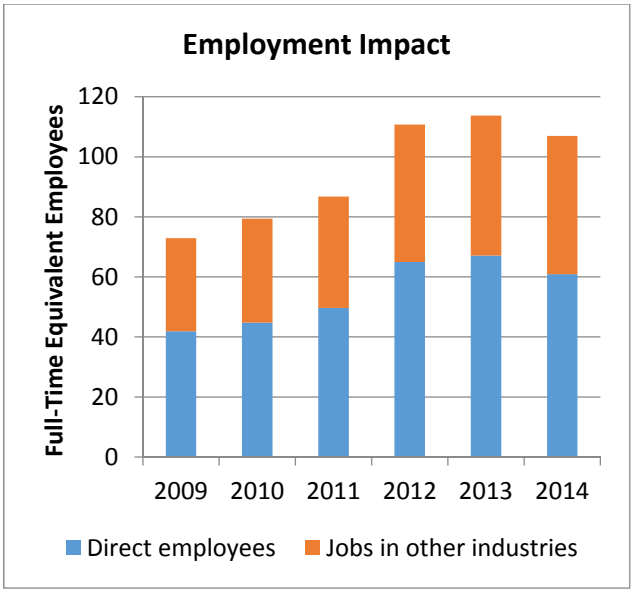
Summary of STCHC Financial Impact

It is clear from the analysis above that STCHC is a rapidly growing organization, investing in capital and adjusting to the typical shifts in staffing levels, total expenses, and revenue mix that health centers experience when they transition to becoming an FQHC and begin adding capacity to serve more patients. The grant funds provided by BCM throughout the period clearly provided important opportunities for expansion and played a key role in stabilizing the organization as it endured natural growing pains any health center would experience as service sites and programs grow.

Economic Impact of STCHC and BCM Funding

The charts below provide context on the economic and employment impact made possible by STCHC's robust and growing operations. Using IMPLAN, integrated economic modeling software, the analysis below applies the "multiplier effect" to capture the direct, indirect, and induced economic effects of health center business operations. The blue portion of the columns in each chart speaks to the direct employment and economic activity of the health center, while the orange portion speaks to the additional economic activity and employment generated by the purchases of local goods, services, and labor made by health center suppliers (indirect impact), as well as similar purchases made at a household level by employees of the health center and its suppliers (induced impact).





The summary impact figures for STCHC, along with BCM funding over the six years are as follows:

- On a cumulative basis, STCHC contributed $41.2 million in total direct economic impact and an additional $29.9 non-direct impact, for a **total economic impact of $71.1 million** between 2009 and 2014.
- On a cumulative basis, STCHC generated a total of $2.5 million in state tax impact and another $5.9 million in federal taxes, for a **total tax impact of $8.4 million** between 2009 and 2014.
- STCHC created an additional 19 full-time equivalent (FTE) direct jobs employed annually and another 15 non-direct FTE jobs, for a **total annual employment impact of 34 jobs**.
- This means that **for every dollar spent by BCM** over the review period, **an additional $23 in economic activity and $2.68 in state and federal taxes** was generated by STCHC.

Access Health Louisiana
History of Funding and Operations

About the Organization

Access Health Louisiana (AHL) is a 23-site network of FQHC and School-Based Health Center (SBHC) sites. AHL was founded in 2002 under the name St. Charles Community Health Center, Inc. (STCCHC). It was originally an FQHC created to serve the public health needs of the residents of St. Charles Parish, Louisiana. Soon after, STCCHC collaborated with the parish and the St. Charles Parish Hospital to provide affordable primary care, behavioral health, and dental care for adults and children. STCCHC then quickly expanded to create an additional satellite clinic in Jefferson Parish and Adult Day Care services in Norco, LA.

In the aftermath of Hurricane Katrina, AHL experienced significant growth as regional opportunities to expand primary and behavioral health services were identified throughout the southeast region of Louisiana. The health center now serves seven parishes with numerous community health center and School Based Health Center (SBHC) sites. Within the BCM service area, AHL operates the Tammany Community Health Center, with two locations that opened in 2009 and 2013 (Slidell and Covington, respectively). Also within the BCM service area, AHL opened other new clinics, including the St. Bernard Community Health Center (2013), the Belle Chasse Community Health Center (2012), the Ruth U. Fertel/Tulane Community Health Center (2012), and the South Broad Health Center (2014). All of these sites provide primary care services in a patient-centered medical home (PCMH) model.

Funding History

BCM's relationship with AHL began in 2008 when BCM invited the health center to become part of a BCM-facilitated planning group convened to identify the feasibility of FQHC clinic development in St. Tammany Parish. BCM staff and consultants, St. Tammany Parish government, Slidell Memorial Hospital, and the Covington Food Bank collaboratively sought a solution to the sorely needed development of primary and behavioral health services, and that the best model for this delivery of care was an FQHC. St. Tammany Parish experienced significant increases in uninsured residents as many families were forced to relocate in the wake of widespread flooding associated with Hurricane Katrina. St. Tammany had no primary care infrastructure and very limited mental and behavioral health services for low-income residents; services that did exist were quickly overwhelmed. After Katrina, suicide rates increased dramatically and St. Tammany Parish experienced one of the highest rates in the state. The Covington Food Bank, whose board of directors included an influential retired primary care physician, was interested in development of an FQHC to serve their rapidly growing client base.

With modest operational support promised by the parish and consultative support provided by BCM, then STCCHC applied for and received federal Change in Scope approval to expand its primary care services into St. Tammany Parish. In July 2009, the St. Tammany Community Health Center in Slidell opened and became the first FQHC site in the large parish. It was followed by a second behavioral health clinic located in Covington in June 2013. Both clinics were immediately successful and patient volumes increased steadily. STCCHC, already an FQHC, formally change its name to Access Health Louisiana in 2014 to reflect its planned growth into five additional parishes. Additional locations subsequently developed within the BCM service area include the first ever clinics in Plaquemines Parish (the Belle Chase Community Health Center) and St. Bernard Parish (the St. Bernard Community Health Center). In 2014, the South Broad Community Health Center was opened to serve a large low-income population in the Central City and Broadmoor neighborhoods of Orleans Parish.

School-Based Health Centers as a Strategy

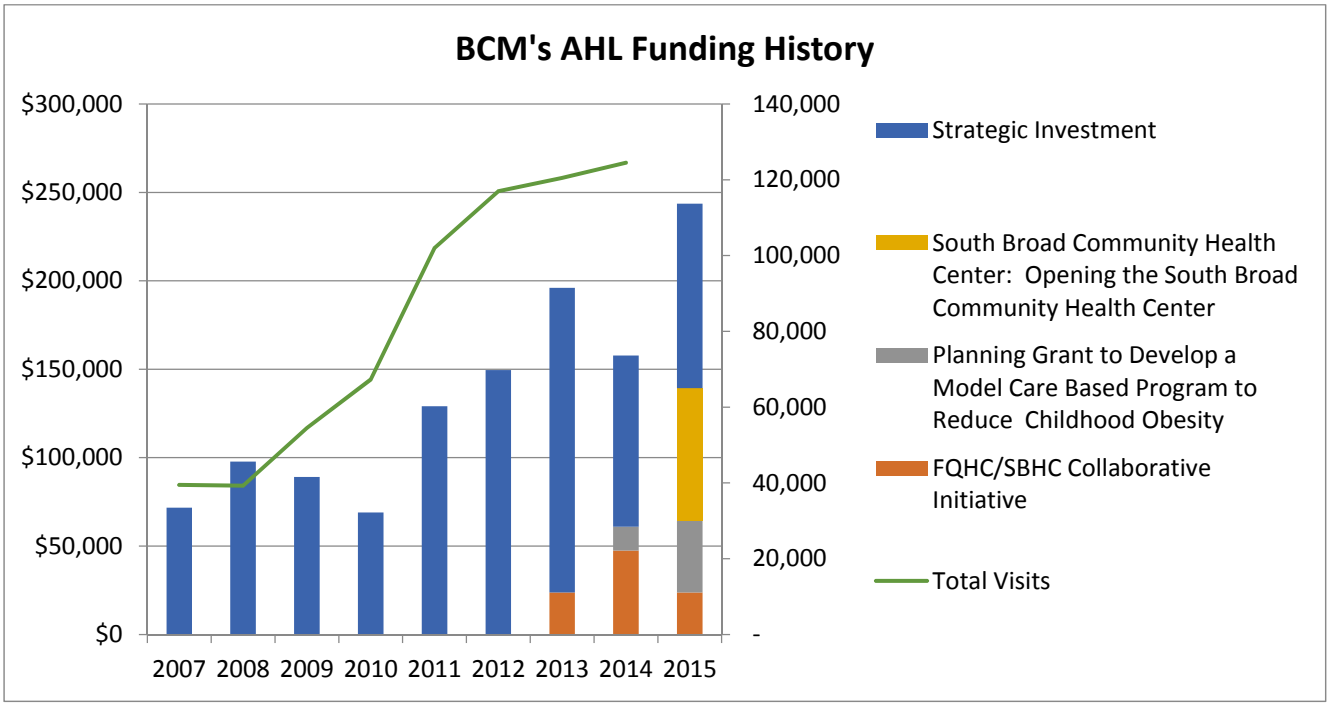
School-Based Health Centers (SBHC), a special FQHC designation provided on-site at elementary, middle, and high schools, were recognized as an important component of primary care network development in the regional post Katrina planning process. Declining state and local school system support threatened existing SBHCs and impeded development of new locations. In 2007, BCM staff pursued a study of the feasibility of a formal linkage of the Jefferson Parish Public School System (JPPSS) with a FQHC. This school was one of the largest systems in the state and also had a large percentage of students receiving free and reduced cost lunches. BCM provided key technical assistance and grant support to aid the successful transition of all five Jefferson Parish SBHCs on both east and west banks of the Mississippi River to AHL governance and operational control; this control was established through development of memoranda of understanding and collaboration among interested parties. Additional AHL service locations include seven SBHCs developed with support of BCM in Jefferson and Orleans parishes. Collaborative agreements exist between AHL and the differing governments, school boards, community hospitals, and public and private entities to ensure this system delivers essential medical care to the people who need them the most: the uninsured, disenfranchised populations.

Summary of Key Grant Investments by BCM

As the BCM/AHL partnership evolved, the need for additional funding to leverage federal, state and local funding opportunities became apparent. The transom grants that were utilized to support specific opportunities are briefly summarized below.

Key BCM Grant Investments in AHL
• **Health Center/SBHC Collaborative Initiative:** BCM strategic funding helped provide operational support for the integration process to convert the five JPPSS SBHCs to AHL. This funding was timely as the collaboration and three-year master plan for sustainability would have otherwise been delayed due to circumstances outside of the partners' control. • **Planning Grant to Develop a Model Care Based Program to Reduce Childhood Obesity:** This planning grant was awarded to develop a model for primary care-based approaches to prevent and reduce childhood obesity and delay the onset of type 2 diabetes. In partnership with the Pennington Biomedical Research Center, AHL developed a sustainable, effective, and cost-effective program adaptable to FQHCs and SBHCs. • **Opening South Broad Community Health Center:** Bridge funding was provided to support initial start-up operational funding for a new FQHC site serving low-income residents in Central City. AHL partnered with the South Broad Community Association to open the South Broad Community Health Center.

The chart below illustrates the investments in AHL made by BCM. It includes both ongoing strategic funding as well as the five transom grants described above. BCM awarded STCHC a total of $224,000 in transom funding and $391,900 in strategic support between 2007 and June 2015.

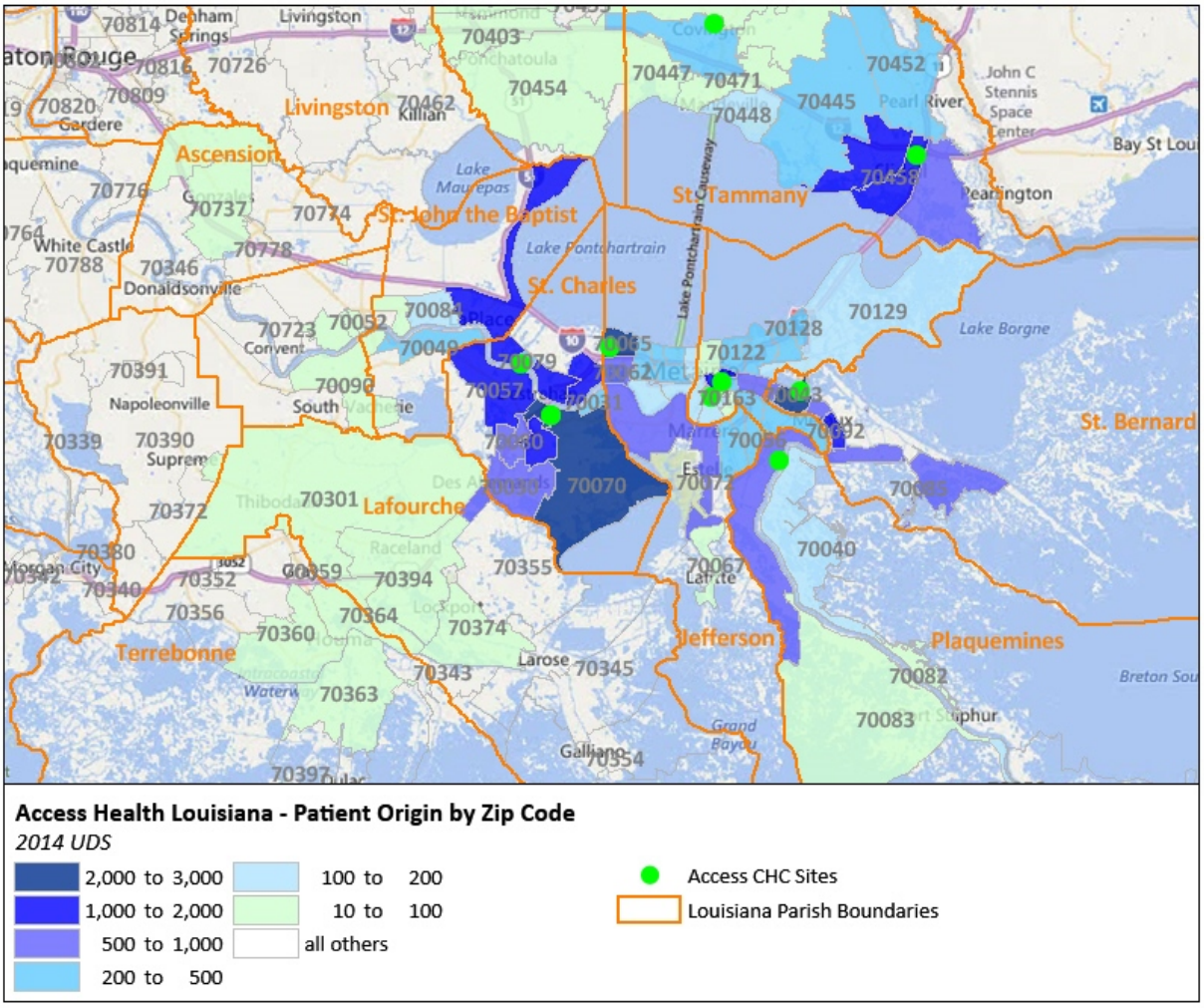


The sections that follow summarize the community, financial, and economic impact of BCM's investments in AHL. Consistent with the STCHC analysis, all patient impact and economic impact analysis of the health center is for the period of 2009 to 2014, while financial impact was calculated from 2007 through 2014.

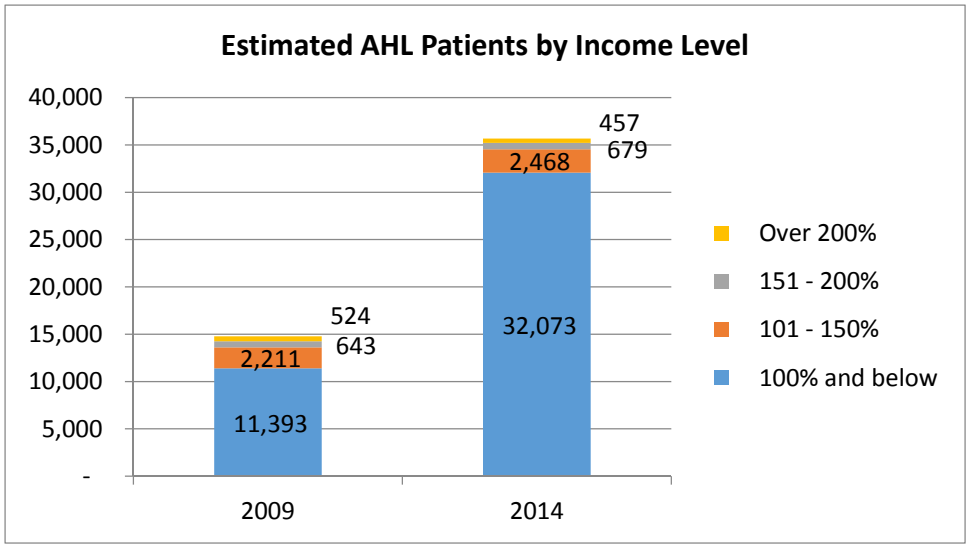
AHL Market Trends and Community Impact

Already on a robust growth path before the 2009-2014 review period, AHL's presence across multiple parishes has grown dramatically, reaching 21,000 more patients annually in 2014 than it did in 2009. Today, the health center sees nearly 36,000 patients each year at close to 125,000 annual medical, behavioral health, dental, and supportive enabling services visits.

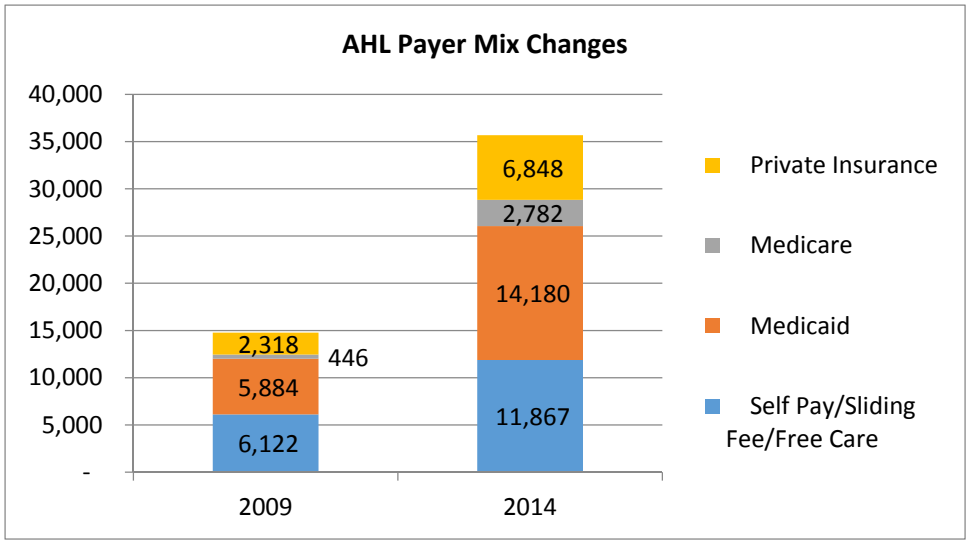
As an FQHC, AHL is required to provide patient data, including by zip code of residence, to HRSA in the form of its annual UDS report. The map below is prepared from AHL's 2014 patient by zip code data and indicates the breadth and depth of AHL's presence in the community. It is clear that the health center has a broad reach, with thousands of patients coming from zip codes across all of the BCM parishes of interest: Jefferson, Orleans, Plaquemines, St. Tammany, and St. Bernard, as well as a strong presence in St. Charles Parish, where AHL began.



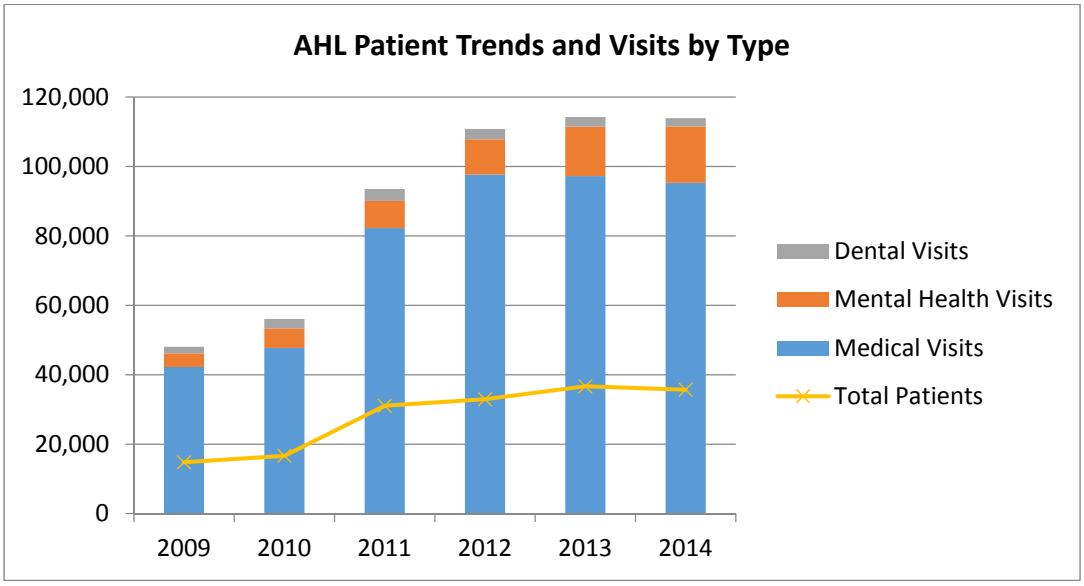
The following charts provide perspective on the shift in patients by income and insurance type between 2009 and 2014. Over the six-year review period, AHL served nearly 21,000 additional individuals at or below the poverty level, as well as modest increase of those between 100% and 200% of the poverty level.



AHL also experienced a large shift in its payer mix, or mix of insurance types. Over the review period AHL gained 8,300 patients insured by Medicaid, by far the best payer type for FQHCs due to cost-based reimbursement. This increase in Medicaid patients that occurred as the uninsured patients decreased is in part due to AHL's investment in enabling services, which include enrollment assistance, as well as the expanded Medicaid eligibility under the 1115 Waiver as discussed in an earlier section. Other changes in the payer mix include an increase in 2,300 insured by Medicare and nearly 4,500 new privately insured patients. Nearly 5,800 AHL patients are uninsured, suggesting challenges still remain, but also indicating the crucial role the health center plays in providing care to the uninsured.



The chart below illustrates the increase in annual visits from 2009 to 2014, as well as providing information on visits by type. While patient growth leveled off in 2013 and 2014 after a period of rapid expansion that began in 2009 and stepped up significantly in 2011 (wherein medical visits nearly doubled), AHL is clearly working to deepen its services to its patient base, as demonstrated by the growth in behavioral health visits *over the period*. Behavioral health visits nearly quadrupled between 2009 and 2014.



AHL Financial Trends and Impact

Capital Link studied AHL's audits for the fiscal years ending February 28th, 2007 through February 28th, 2014 (FY07 through FY14). Below is a summary of the eight-year trends and FY14 results, followed by a discussion of key financial strengths and challenges.

AHL Financial Trends - FY07 through FY14

Revenue and Expense Composition	Target	FY 14	Eight Year Average
Operating Margin	> 1-3%	2.2%	5.8%
Bottom Line Margin	> 3%	3.5%	8.7%
Personnel Related as Percentage of Operating Revenue	< 70-75%	74.8%	78.2%
Operating Revenue Growth Rate		9.0%	23.6%
NPSR Growth Rate		0.5%	27.9%
GCR Growth Rate		62.1%	23.7%
Operating Expense Growth Rate		14.0%	24.8%
Revenue Mix {NPSR}		62.2%	57.2%
Revenue Mix {GCR}		32.7%	33.7%

Liquidity	Target	FY 14	Eight-Year Average
Days Cash on Hand	> 30-45 Days	50 Days	18 Days
Current Ratio	> 1.25	3.9	1.6
Days Net Patient Receivables	< 60-75 Days	23 Days	35 Days
Days in All Receivables	< 60-75 Days	28 Days	45 Days
Days in Accounts Payable	< 60 Days	5 Days	55 Days
Working Capital Growth Rate		46.3%	-80.1%

UDS Measures	Target	FY 14	Eight-Year Average
Patient Visits		124,495	83,053
Patient Growth Rate		-2.7%	21.3%
Operating Revenue Per Patient		$546	$512
Operating Expense Per Patient		$534	$483
Operating Revenue Per Visit		$157	$143
Operating Expense Per Visit		$153	$135

Financial Strengths

On the statement of activities, total operating revenue grew by 299% and total operating expenses grew by 327% over the review period, for an annual average growth of an impressive 43% and 46% respectively. Although expense growth slightly outpaced revenue growth, AHL was still able to report positive operating margins in all years, with the exception of FY08 when the health center broke even. This trend of strong operating margins in nearly all years indicates a sustainable track

record of financial performance. Finally, net patient service revenue (NPSR) fluctuated as a proportion of total operating revenue over the review period, but averaged 57% as a percent of total operating revenue, indicating that the health center operates close to the national average of 60% and a reduced reliance on grant funding as the health center builds its patient revenues.

On the balance sheet, AHL's level of leverage (Total Liabilities divided by Total Net Assets) was well-below the recommended maximum of 3.0 in all years except FY08. This low level of leverage indicates that AHL has not been overly burdened by debt or current liabilities. Similarly, AHL was below the recommended maximum for Days in Accounts Payable in all but one year (FY11), indicating a strong ability of the health center to pay bills as they come due. The health center is also extremely successful in its billing and collections policies and procedures, with Days in Net Patient Receivables far below the recommended range of 65 to 75 days in all years studied.

Financial Challenges

On the statement of activities, AHL's primary challenge is keeping its expenses in control as it continues to grow in order to sustain its positive operating results. In particular, personnel-related expense (salaries, fringe and contracted services) as a percent of total operating revenue was above the recommended maximum of 70% in all years, averaging 78% over the review period. However, this measure declined to 75% in FY14 from its maximum of 80% in FY11 and FY12, indicating a trend in the right direction.

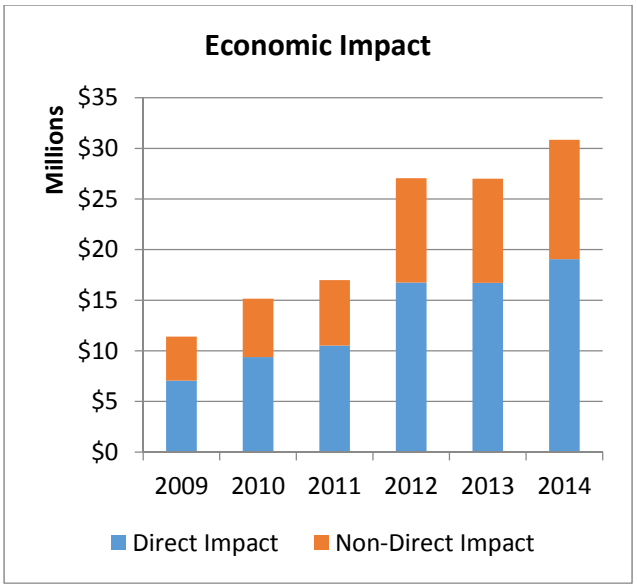
On the balance sheet, AHL has experienced some liquidity challenges. Days Cash on Hand was below the recommended level of 30 days for most of the review period through 2012, recovering to 45 days in FY13 and 50 days in FY14. Lower Days Cash on Hand means the health center has fewer reserves available to help weather fluctuations in cash inflows that health centers occasionally experience, so the recovery in recent years is a positive trend. Current ratio was also the recommended minimum of 1.25, reflecting broader liquidity challenges many health centers can experience when in a rapid expansion mode such as the one AHL experienced through 2012.

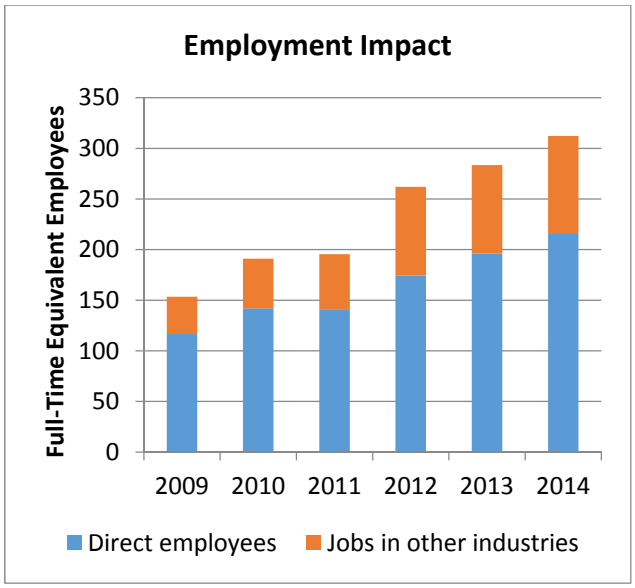
Summary of AHL Financial Impact

It is clear from the above analysis that AHL, the largest FQHC network in the state, has weathered a significant period of growth successfully, exhibiting steady growth in patients and revenues. However, even this robust organization is not without its financial challenges as cash reserves are quite slim, as is the case for most FQHCs. The grant monies provided by BCM, although a small proportion of total operating revenue, appear to have allowed the health center to continue to flourish and invest strategically while maintaining a viable financial profile.

Economic Impact of AHL and BCM Funding

The charts below provide context on the economic and employment impact made possible by AHL's robust and growing operations. Using IMPLAN, integrated economic modeling software, this analysis below applies the "multiplier effect" to capture the direct, indirect, and induced economic effects of health center business operations. The blue portion of the columns in each chart speak to the direct employment and economic activity of the health center, while the orange portion speaks to the additional economic activity and employment generated by the purchases of local goods, services and labor made by health center suppliers (indirect impact), as well as similar purchases made at a household level by employees of the health center and its suppliers (induced impact).





The summary impact figures for AHL, along with BCM funding over the six years are as follows:

- On a cumulative basis, AHL contributed $66.7 million in total direct economic impact and an additional $41.1 non-direct impact, for a **total economic impact of $107.8 million** between 2009 and 2014.
- On a cumulative basis, AHL generated a total of $3.7 million in state tax impact and another $9.0 million in federal taxes, for a **total tax impact of $12.7 million** between 2009 and 2014.
- AHL created an additional 111 full-time equivalent (FTE) direct jobs employed annually and another 55 non-direct FTE jobs, for **total annual employment impact of 166 jobs**.
- This means that **for every dollar spent by BCM** over the review period, **an additional $84 in economic activity and $16 in state and federal taxes** was generated by AHL.

Conclusions

Although Hurricane Katrina caused unprecedented damage across Greater New Orleans, it also created a unique window of opportunity. In the aftermath of the storm, BCM was able to introduce new approaches to increasing access to care for uninsured and underinsured resident via the creation of new FQHCs. The subsequent long-term funding streams have altered the landscape of primary care for New Orleans. Based on financial analysis included in this report, funding from BCM appeared to play a pivotal role for both health centers. This conclusion is particularly true for STCHC as it navigated growth, recruitment, and funding challenges. BCM's sustained assistance appears to have helped stabilize both health centers' financial standing, while also leveraging programmatic, collaborative, and financial resources for additional expansion and patient growth. Programmatically, BCM appears to have served as a catalyst for significantly expanding and improving access to primary health care in New Orleans. Ten years after Hurricane Katrina, all five parishes served by BCM have acquired at least one FQHC clinic, and Orleans, Jefferson, and St. Tammany have multiple FQHC sites.

On the ten-year anniversary of Katrina, it may be tempting to assume that all recovery is complete. However, Greater New Orleans FQHCs will still need assistance surviving the uncertain funding environment going forward. Specifically, at the time this report was written, the Medicaid 1115 waiver is set to expire in early 2016. If this expiration occurs, FQHCs in the region will see a major negative shift in their payer mix as many who gained insurance through Medicaid revert to being uninsured. If all FQHCs in the region lose cost-based reimbursement for a large swath of their patients, it will be more important than ever for continued, sustained investment in FQHCs.

In addition to the need for ongoing funding and perhaps additional support in the event that funding streams change, FQHCs are also going to need assistance with the integration of behavioral health services, which is next on agenda for all FQHCs at the state and national level. This transition will require an investment in the transformation of care, as health centers shift their patient care team structure, train and recruit staff, and invest in new capital projects to accommodate a more comprehensive model of care that truly integrates primary and behavioral health care.