Capital Plans and Needs of Health Centers

A National Perspective

Prepared by Capital Link | 2015

CAPITAL LINK

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Capital Link is a national, non-profit organization that has worked with hundreds of health centers and Primary Care Associations for over 15 years to plan capital projects, finance growth, and identify ways to improve performance. We provide innovative consulting services and extensive technical assistance with the goal of supporting and expanding community-based health care. Established in the late 1990s as a joint effort of the National Association of Community Health Centers (NACHC), several state-based Primary Care Associations (PCAs), and the Bureau of Primary Health Care, Capital Link grew out of the community health center family and continues to support it through creative capital development and analytic activities. For more information, visit www.caplink.org.

Introduction

In the transforming health care marketplace, access to primary and preventive care is critical to achieving the "triple aim" of health reform: improving population health, enhancing the patient experience, and reducing the per capita cost of care. Significant federal investments approved as part of the American Recovery and Reinvestment Act (ARRA) and the Affordable Care Act (ACA) have fueled the growth of Section 330 Federally Qualified Health Centers (FQHCs), who served almost 22 million patients in 2013—an increase of 4.6 million patients since 2008. While most of the federal investments were made in the form of operating grants, a portion of the funds were made available as capital grants, which health centers used to build their physical infrastructure.

The impressive growth achieved in the health center sector to date is dwarfed only by the remaining need. Today, almost 62 million people in the United States do not have a regular source of primary care.[3] Health centers are striving to fill this tremendous gap, and assuming continued federal support and a rate of patient growth consistent with historical trends, appear to be on track to serve 32 million patients by 2020. In doing so, health centers will face numerous hurdles, including gaining access to sufficient capital to expand their facilities and to accommodate additional providers and patients.

The purpose of this report is to present findings on the scale and types of capital needs identified by health centers and to assess whether this level of investment would be sufficient to enable them to achieve their growth goals. This analysis also provides insight into new and emerging needs among health centers that may result in a demand for financing that goes beyond traditional "bricks and mortar" and an interest in participating in projects that address the broader health of the community.

Community Health Center Capital Project Plans and Funding Needs: 2015 Overview of Respondents

Capital Link administered an online assessment of health center capital needs to approximately 1,200 FQHCs nationally in early 2015. Three hundred and sixteen health centers responded from 49 states, DC, and Puerto Rico, representing a response rate of 26%. Thirty-eight percent of respondents serve urban areas, 37% serve rural areas, and 25% serve both urban and rural communities. At the time of the assessment, 29 states including DC were expanding Medicaid eligibility as anticipated through the ACA, via "regular" or alternative means. Sixteen states were not expanding Medicaid eligibility, and six states were engaged in executive-level discussions regarding potential expansion.[4] Given that health centers located in states that are expanding Medicaid eligibility are likely to experience greater opportunities for growth, we expected that health centers from expansion states might disproportionally respond to the assessment. In fact, 63%

[3] National Association of Community Health Centers, *Access Is the Answer: Community Health Centers, Primary Care & the Future of American Health Care* (March, 2014).

[4] See Appendix A. Kaiser Family Foundation, *Status of State Action on the Medicaid Expansion Decision* (March 6, 2015).

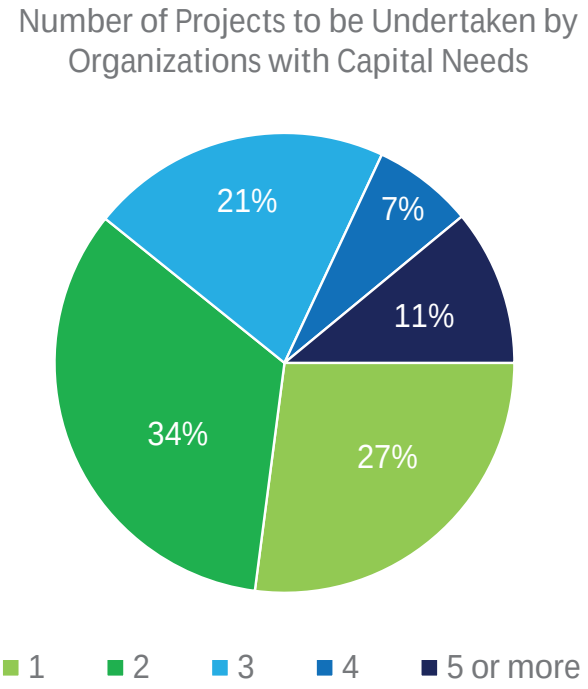
of respondents were located in expansion states, 23% were located in non-expansion states, and 14% were located in states considering expansion.

The assessment covered a range of topics, including:

- Near-term facility needs and challenges
- Need for various types of debt:
  - Short-term operating capital
  - Growth capital
  - Long-term debt
  - Refinancing
- Collaborative projects to address the social determinants of health

Assessment Results – Facility Projects

Seventy-nine percent of respondents reported that they expect to undertake one or more facilities-related capital projects over the next several years. Extrapolated nationally, the responses suggest that health centers plan to undertake more than 2,300 projects in total, with many health centers expecting to take on multiple projects. As shown in the following chart, 73% of respondents with planned projects intend pursue two or more projects. Health centers also reported that they have specific near-term plans for approximately 52% of these anticipated projects.

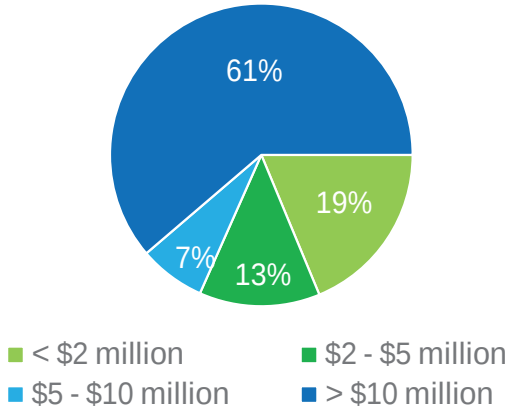


In order to achieve the 2020 goal of serving a total of 32 million patients, health centers will likely need to invest $8.5 billion.

Estimated Project Costs

The expected total cost of planned projects is close to $4.6 billion. This level of investment would enable health centers to build almost 12 million square feet of space, accommodating 6,100 new providers, with the capacity to serve 5.4 million new patients. Given that many health centers expect to take on more than one project, 61% of centers expect their total project budgets to exceed $10 million; an additional 20% expect to spend between $2 million and $10 million.

Budget Sizes of Projects being Undertaken per Health Center

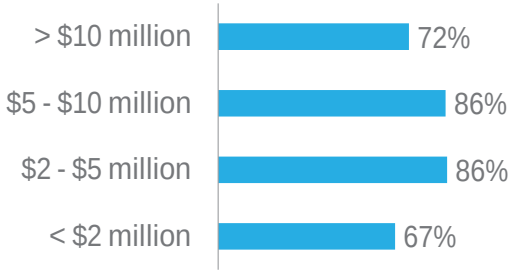


Challenges and Obstacles to Meeting Facility Financing Needs

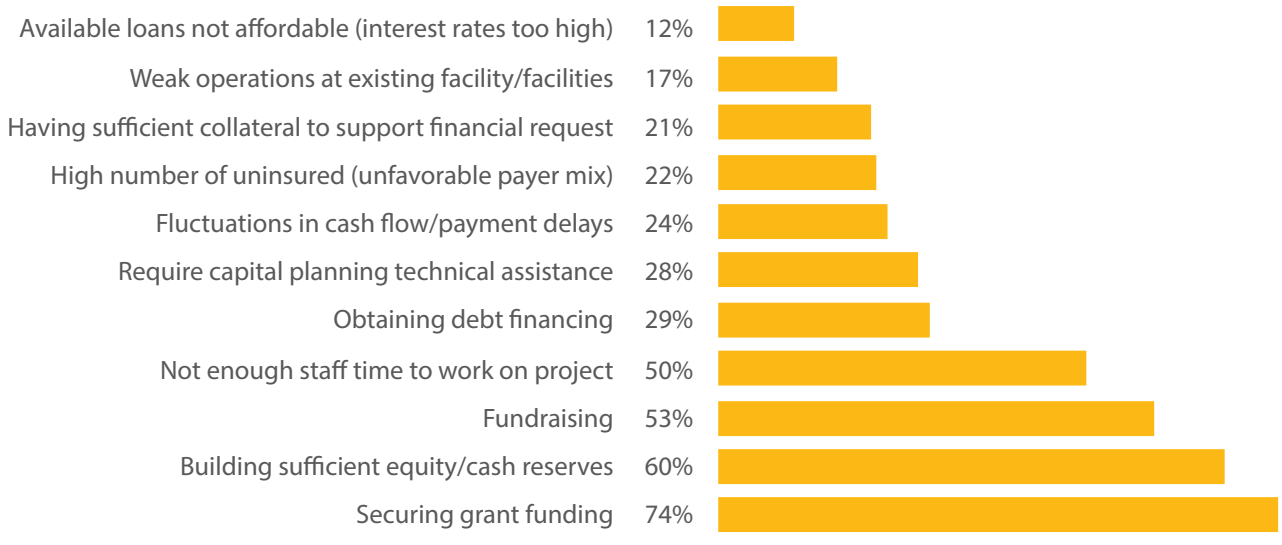
While 25% of health centers reported that they have assembled all the capital they need to pursue their near-term projects, 75% reported having funding gaps. While significant funding gaps were reported for projects of all sizes, 86% of health centers with "mid-sized" projects ranging from both $2-$5 million and $5 million-$10 million reported funding gaps.

Health centers indicated a range of challenges in meeting their facility financing needs, and the most prevalent were related to devoting sufficient staff time to the project and securing grants, equity, and fundraising—underscoring the importance of raising "free money," and the sector's relatively strong debt aversion.

Health Centers Reporting Funding Gaps by Project Size



Challenges and Obstacles to Meeting Facility Financing Needs



Will Planned Projects Be Sufficient to Meet Growth Goals?

Even if health centers are able to overcome the identified challenges and successfully raise capital to complete anticipated projects, the increase in capacity—which should accommodate an additional 5.4 million patients—falls considerably short of the 10 million additional patients expected to seek care at FQHCs by 2020. In order to achieve the 2020 goal of serving a total of 32 million patients, health centers will likely need to invest $8.5 billion in new physical infrastructure, which is almost $4 billion more than currently anticipated. This higher level of investment would support the construction or renovation of 22 million square feet of space, and accommodate 11,300 providers to serve an additional 10 million patients annually. Above and beyond this need for new facilities investment, many health centers currently provide services to patients in old, outdated facilities that are in need of repair and replacement. The capital costs associated with repairing or replacing these older existing facilities is not fully reflected in this estimate.

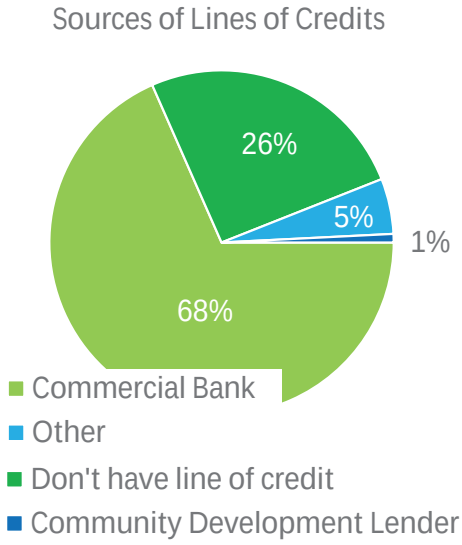
Need for Various Types of Capital

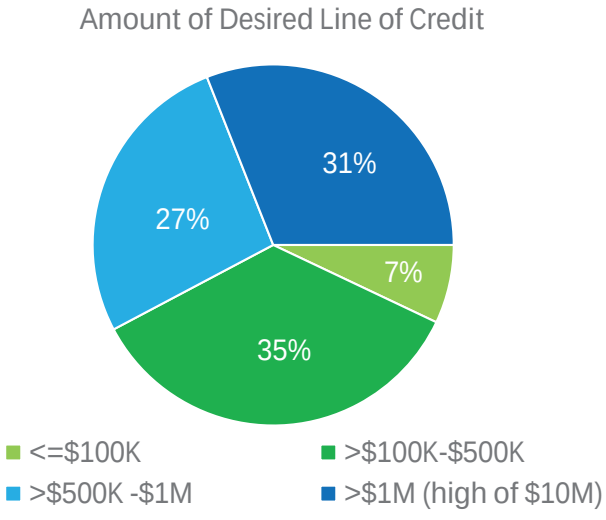
While long-term debt to support facilities development (discussed later in this section) continues to be a major need for health centers, other types of capital are also needed to support operational growth and the adoption of optimal business practices. This section examines health centers' needs for various types of capital and the current funding sources, or lack thereof, available.

Operating Lines of Credit

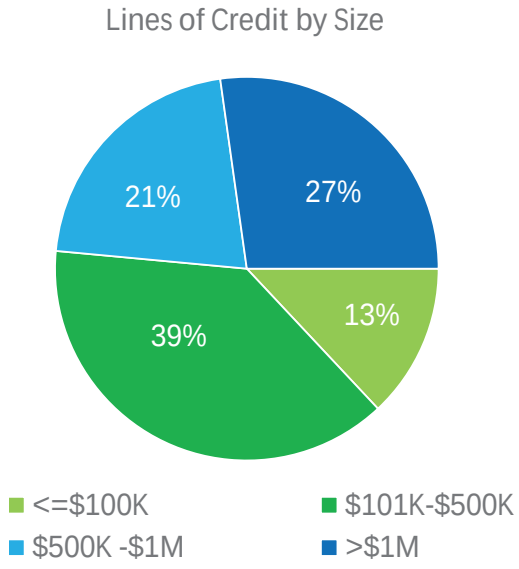
Lines of credit are typically used to provide cash flow liquidity when the timing of cash collections from accounts receivable or grants are delayed. Approximately 75% of the responding health centers indicated they had a line of credit, the vast majority from commercial banks. The lack of a line of credit for 26% of respondents could indicate that these centers are less well-positioned to withstand a short-term disruption in their cash flow as compared to those with a credit line.

As shown in the chart on the following page, the majority of health center credit lines are less than $1 million (73%), with 13% being less than or equal to $100,000. The median line of credit size was $365,000; of those with lines of credit greater than $1 million, the average size of these lines is $2.75 million.



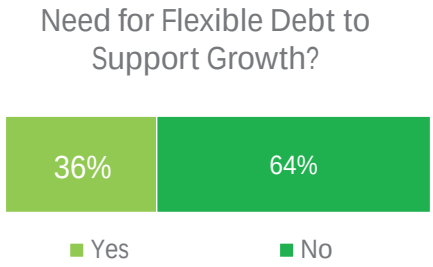


Assuming a typical line of credit would cover approximately one month's payroll, the sizes of these lines of credit imply a median budget of $6 million and a range of approximately $1.4 million to $45 million. In fact, health center budgets are quite a bit larger than these estimates suggest. In 2013, the median health center budget was roughly $10 million, with a range of $1.5 million to $64 million at the fifth and 95th percentiles, respectively. Not surprisingly, most health centers reported that the size of their current line of credit is not sufficient to meet their needs. The chart below shows the proportion of health centers in each size category, based on their desired credit line needs. The median desired line of credit was $750,000, which would accommodate a budget of approximately $12 million, which more closely corresponds to the current median budget size for the sector.

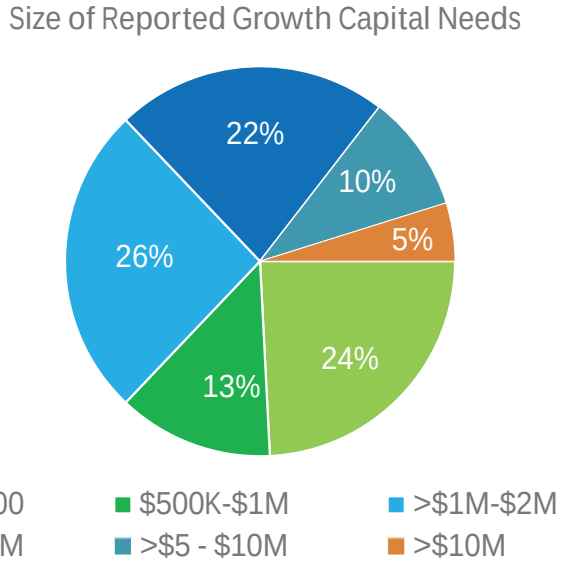


Growth Capital

In the assessment, health centers were asked about their need for flexible debt—loans not tied to a capital project but rather used as working capital to support growth. The concept of "growth capital" is likely new to many nonprofit managers. In the for-profit world, equity or venture capital is frequently used for this purpose. In the nonprofit world, growth capital is generally available (in the form of unsecured loans) to only the financially strongest organizations. More than one-third of respondents (36%) identified growth capital as a need.



For those that responded in the affirmative, approximately 37% reported needs of less than $1 million, almost half (48%) reported needs between $1 million and $5 million, and 15% reported needs exceeding $5 million.



The assessment prompted health centers to identify uses for this type of flexible capital and gave them a variety of choices as detailed in the chart below. Respondents reported a broad range of anticipated uses in four main categories:

1. **Working capital for expansion:** Almost all affirmative respondents (and even a few who reported no growth capital needs) identified "covering possible losses during start-up of a new site" and "covering costs of adding providers for expansion of coverage" as their most prevalent needs.

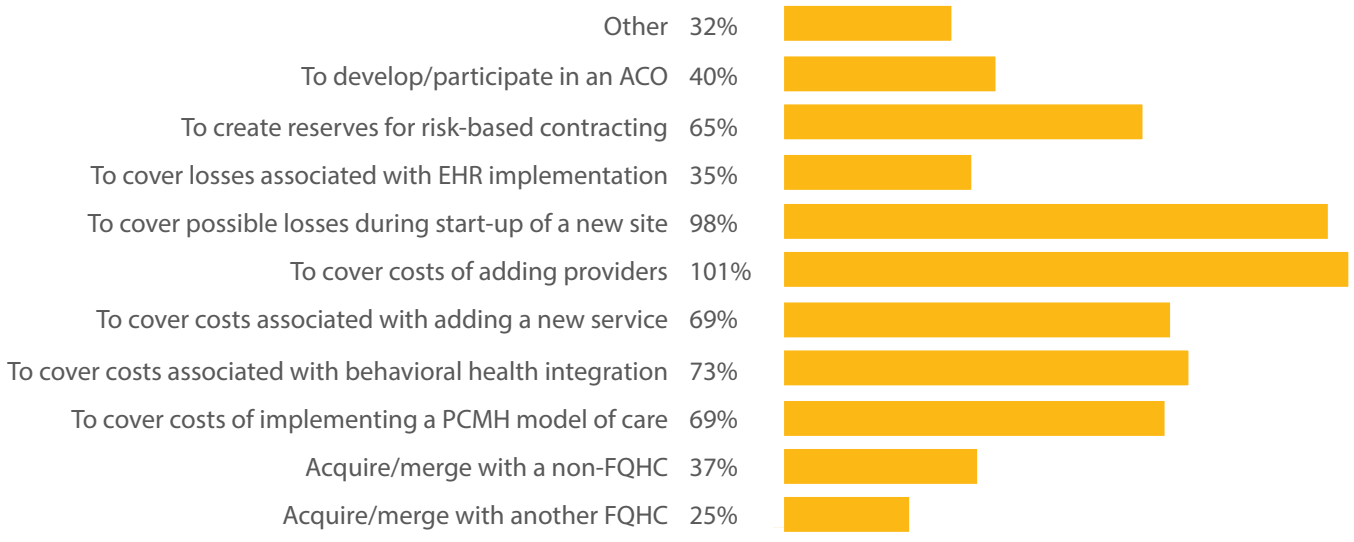
2. **Changing service delivery:** Between 69% and 73% of "yes" respondents identified "covering costs associated with adding a new service," "covering costs associated with behavioral health integration," and "covering costs associated with implementing a Patient Centered Medical Home model of care" as the next most prevalent needs.

3. **Preparing for payment reform:** Between 40% and 65% of "yes" respondents identified "covering costs associated with developing/participating in an ACO" and "creating reserves for risk-based contracting/ transition to managed care" as uses for growth capital financing. All but one of the respondents who indicated a need for $10 million or more in flexible debt marked one or both of these uses. This finding suggests that as payment reform takes shape across the country, at least some centers anticipate substantial financing needs in order to participate in the evolving marketplace.

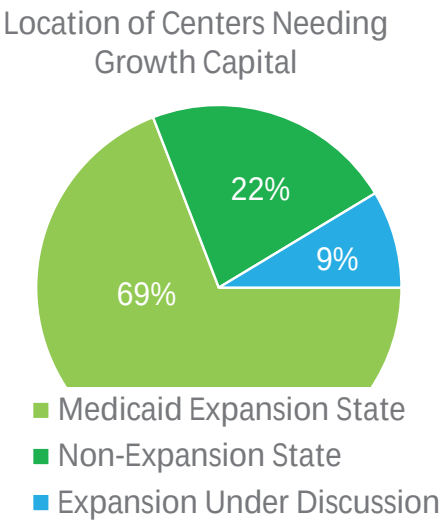
4. **Mergers and Acquisitions:** Respectively, 25% and 37% identified "acquiring/merging with another FQHC" and "acquiring/merging with a non-FQHC" as an anticipated need for growth capital.

Anticipated Uses for Growth Capital

For health centers responding "yes" to growth capital needs



While the need for growth capital is likely to exist across the sector, a significant majority of centers responding positively to this question (78%) were located in states that have expanded Medicaid under the ACA or that have implemented or are awaiting approval for an alternative expansion plan. It seems likely that the reason for this concentration is that these centers are seeing an increase in demand and perceive a need to expand capacity or services, and/or they are more confident that they will be able to make additional debt service payments due to improvements in their payer mix as a result of Medicaid expansion.



It should be noted that a significant number of "yes" respondents (32%) checked "Other" for their use of flexible capital, but many of the specific responses either fell into one of the four main categories or could be accomplished using standard secured debt (i.e., mortgage to purchase land, facility expansion/renovation, or new capital project). That said, these responses might also reflect some centers' recognition that they do not have the cash equity or alternative collateral required by lenders for a standard commercial mortgage for a facility construction project.

While a sizable portion of health centers have identified a need for flexible growth capital, it is important to note that there are very few products in the marketplace today that are designed to meet this need for nonprofits. Historically, sources of growth capital for nonprofits have been limited to general support grants from philanthropies. However, these grants are generally much smaller than the amounts health centers have indicated they need and have become more difficult to secure as foundations tie their grants to specific programs and outcomes.

Some Community Development Financial Institutions are beginning to make growth capital loans available, or are considering doing so. In addition, another product that could be source for this type of capital, and is just beginning to be tested in some markets, is the Social Impact Bond (SIB). With a SIB, nonprofits pledge to assume responsibility for, and lower the cost of providing, social services currently paid for by government agencies. In return for taking on a set of specific programs or the responsibility for caring for specific populations, the nonprofit is paid an agreed upon amount and potentially shares in the savings generated. The upfront program costs are covered by the SIB proceeds with bond holders taking the risk that while the savings may not materialize, they will earn an attractive return on their investment if the savings are substantial.

Medium-Term Debt – Equipment Financing

The assessment revealed that the vast majority of participating health centers (75%) had no current outstanding loans for equipment or Electronic Health Records (EHR) systems. Given that many health centers have accessed grants to build their Health Information Technology infrastructure and/or relied on "Meaningful Use" payments to support these investments, this finding is not surprising. In addition, many health centers finance equipment purchases as part of larger facility financings and therefore may not need separate equipment loans.

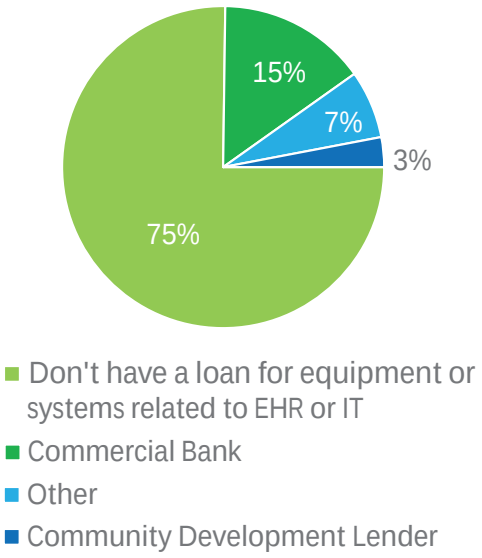
Of those that did have separate equipment loans, the majority of them were from commercial banks. Banks are generally comfortable making this type of loan to almost any business as they typically are relatively small, and collateral values can be readily determined.

Interestingly, despite the low number of health centers with existing equipment/EHR loans, a significant percentage of respondents indicated the need for one in the near future. A substantial majority (74%) of these centers are located in states that have expanded Medicaid or are likely to soon.

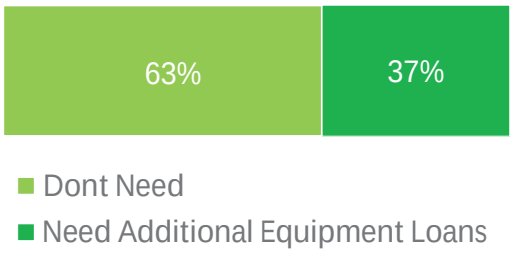
Longer-Term Debt – Facility Projects

A much larger number of the responding health centers had facility-related long-term debt (68%) rather than separate equipment loans. While commercial banks continue to be a major provider of facility loans, their share is substantially less than their share of equipment loans. In the facilities financing arena, community development and other alternative lenders play a much larger role. This finding is not surprising given the perceived risk that these generally larger loans pose to a health center's financial stability. Most community development and alternative lenders are more comfortable with this type of risk than commercial banks.

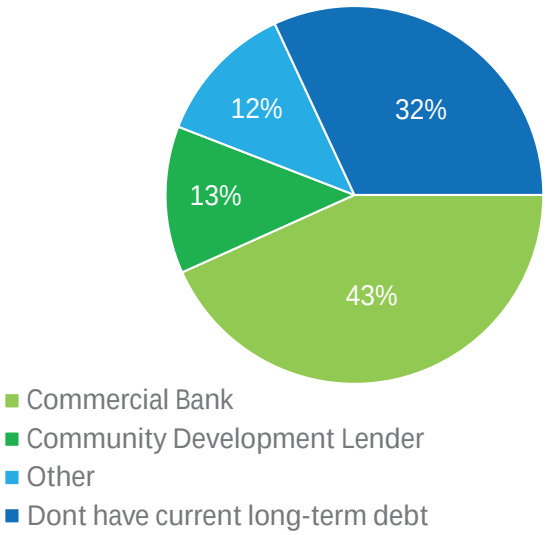
Sources of Equipment and EHR Loans



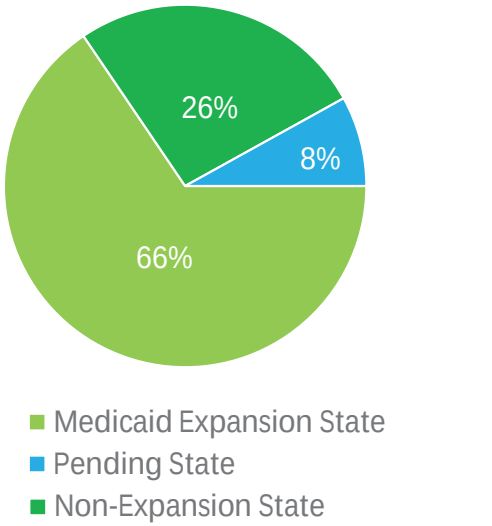
Need Equipment / EHR Loan



Current Sources of Long Term Debt

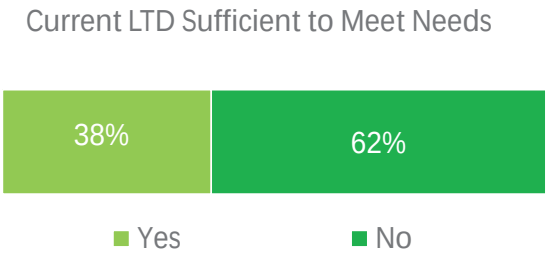


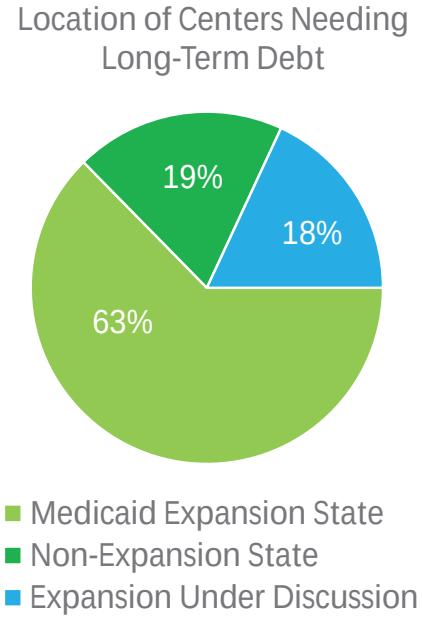
Location of Centers Needing Equipment Loans



It appears that health centers may be becoming more comfortable with the idea of borrowing money to fuel growth. As the chart below shows, a majority of centers (62%) think they will need to borrow additional funds to realize their contemplated growth plans.

This finding represents a significant change from health centers' typical risk aversion and preference for capital campaigns to fund facility needs. As illustrated in the chart below, the vast majority (81%) of health centers with long-term debt needs are located in states that have expanded Medicaid or are considering doing so. This may be an indication that the rapid influx of new patients is pushing health centers to accomplish their capital projects more quickly —and as a result, is enhancing their willingness to consider debt over lengthy fundraising activities.





Refinancing

Most health centers do not appear to have an immediate need to refinance their existing debt. Only 13% of respondents indicated a need to refinance—and of these, over half indicated that their facility financing needs were challenged by their ability to secure additional debt financing and/or that the weak performance of their current operations made borrowing additional funds difficult. Over 72% of those who indicated a need to refinance were located in states that had expanded Medicaid (or planned to), indicating that some of this activity may be driven by capital expansion planning.

Projects to Address the Social Determinants of Health

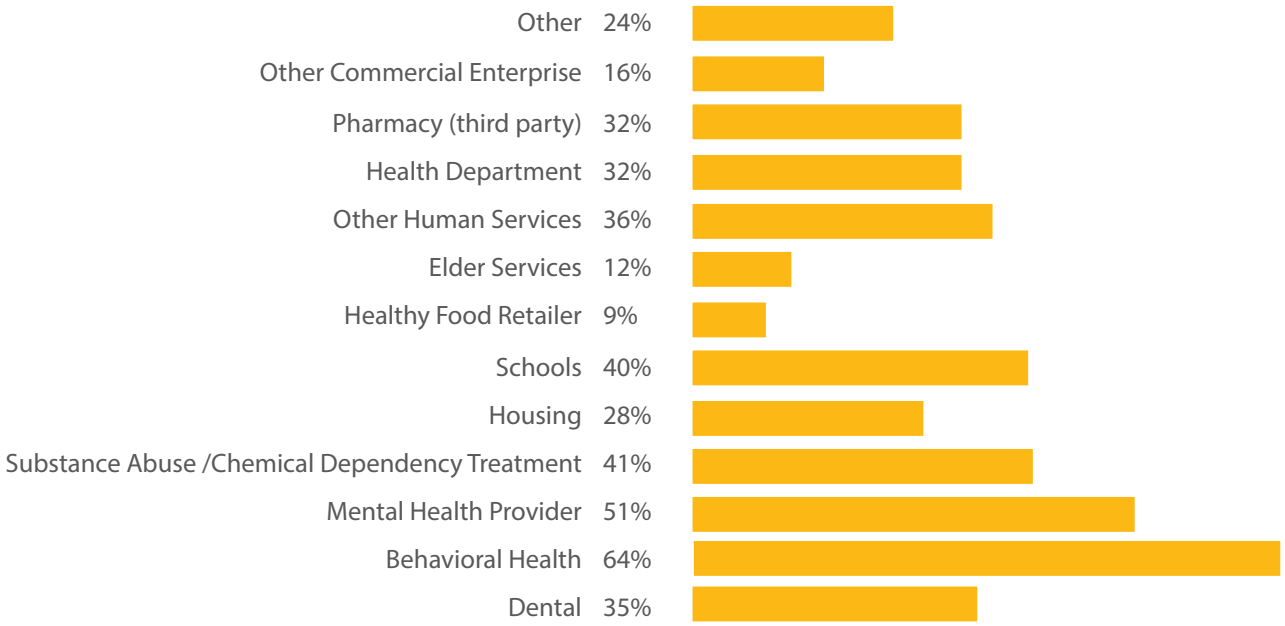
Health policy experts are increasingly turning their attention to issues related to population health. They are recognizing the need to address the "upstream factors" that affect the health of individuals and communities by integrating health services with other social services and community assets. This emphasis on the "social determinants of health" in many ways aligns well with health centers' focus on serving low-income populations and eliminating barriers to care and good health. Our assessment sought to document the extent to which health centers are currently considering capital projects that involve co-location or collaboration with a range of third parties in order to address certain factors affecting the health of their communities. We also sought to document health centers' interest in pursuing such projects in the future if they are not doing so at this time.

Co-location or Collaboration

One-third of respondents indicated that they are considering co-locating or collaborating with a separate entity on a near-term capital project related to addressing one or more of the social determinants of health. These respondents also specified a range of interests, as shown in the chart below.

Projects Involving Co-Location or Collaboration, by Type

Of "yes" responses, proportion with near term projects



The types of co-located collaborative projects on which health centers are currently focusing appear to be closely aligned with policy priorities on both federal and state levels. Integration of behavioral health (and related mental health services and substance abuse services) with primary care appear to be health centers' top priorities. These priorities, along with dental services and pharmacy, have been emphasized by the Health Resources and Services Administration as important dimensions of health center services. Other priorities—such as co-location in schools through school-based health centers and partnering with health departments or other human service providers—are often emphasized at the local and state levels to promote care coordination and to provide "one stop shopping" for patients.

Certain "newer" collaboration opportunities, such as co-locating with low-income or affordable housing or healthy foods retailers, are beginning to capture health center interest even if the prevalence of near-term projects appears to be somewhat limited. The importance of adequate housing, particularly for homeless populations, is a well-documented necessity for achieving positive health outcomes for this vulnerable population. Likewise, the obesity epidemic and the lack of access to healthy foods in many low-income communities is galvanizing interest in addressing these concerns.

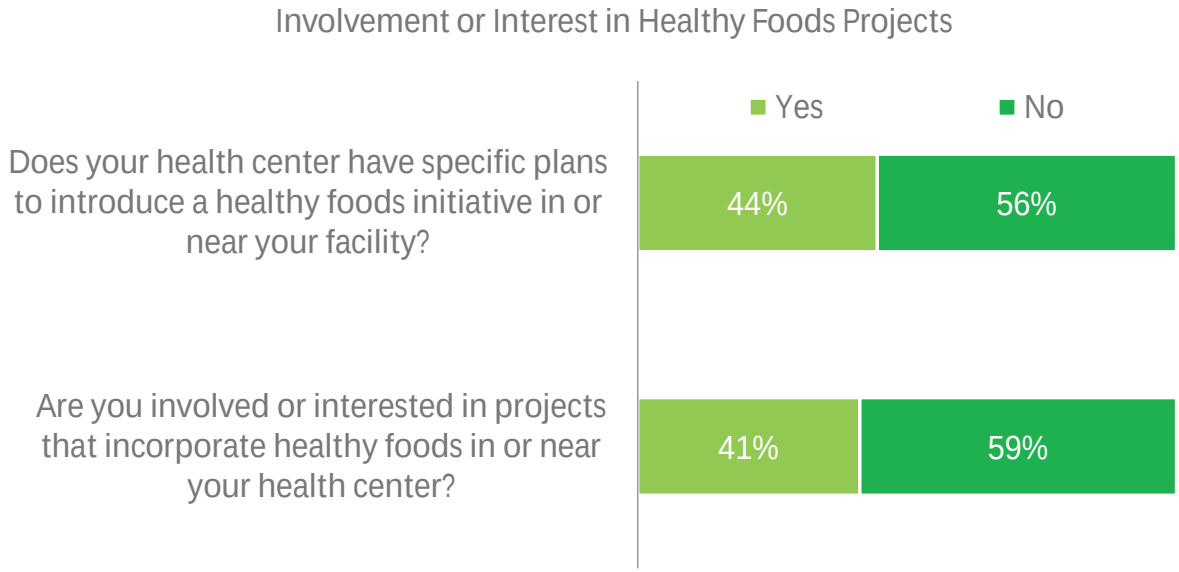
The assessment delved into health center interest in participating in projects specifically related to housing and healthy foods in order to gauge the potential for these types of projects in the future.

Housing

While only 8% of health center respondents indicated they had near-term projects that involved co-locating or collaborating with various types of housing at this time, 31% said they were interested in projects related to affordable housing, including those for homeless populations and/or migrant/seasonal farmworkers. Seventy-nine percent of respondents said they would be interested in constructing a clinic in a building that also included affordable housing units. The responses to the more general follow-up questions may suggest that health centers are by and large in the early stages of considering how best to participate in the housing sector, but have yet to formulate that interest into firm plans.

Healthy Foods

While relatively few health centers identified specific capital projects they were pursuing with healthy food retailers, they nevertheless have fairly strong levels of current or near-term participation in projects that incorporate healthy foods in or near the health center. As shown in the chart below, 41-44% of health centers had some involvement with healthy foods projects.



It appears that these projects are mainly within the "four walls" of the health center, involving hiring nutritionists, adding a kitchen for cooking demonstrations, and launching a healthy eating initiative. Fifty-four percent also indicated an intention to undertake a healthy foods initiative at an external location. So while most health centers may not be considering co-locating with a healthy foods retailer, they are likely collaborating with farmers markets, food banks, and other community efforts to improve their patients' access to healthy foods.

Conclusion

As health centers continue to grow to serve more patients through a widening array of services, their capital needs remain substantial. In addition to the estimated $8.5 billion in capital needed for facilities projects, health centers are also beginning to seek capital for non-facilities-related growth needs, including practice transformation, payment reform transitions, and mergers and acquisitions of FQHC and non-FQHC practices.

Raising the capital necessary to undertake near-term projects continues to be a challenge for health centers, especially in the area of raising grants/equity for their projects. Increasingly, they are anticipating a need for and a willingness to take on debt to enable them to achieve their growth goals.

As the policy and payer environments continue to evolve, health centers are also considering ways they might partner with others beyond the health care system to better address the upstream factors that affect the health of their communities. At the current time, interest in considering these types of projects exceeds actual plans to undertake them. Nevertheless, it represents a "growing edge" for the sector. To the extent the policy environment supports a greater focus on these types of activities, it appears that health centers are willing to respond accordingly.

Methodology:

In early 2015, requests to complete Capital Link's online national capital needs assessment were sent via e-mail to the CEOs, COOs, and CFOs of approximately 1,200 FQHCs (including both Section 330 grantees and Look-Alikes). Health centers received three notifications and reminders to participate. The availability of the assessment was publicized in Capital Link's resource bulletin, on its website, on Primary Care Association (PCA) and National Association of Community Health Centers (NACHC) websites where possible, and through other channels in order to ensure that all health centers were aware of the project and invited to participate. NACHC and all PCAs were contacted personally and asked to encourage their members to respond. These methods netted 274 direct health center responses.

Of the direct responses, 104 self-reported that they were located in urban areas, 96 self-reported being in rural locations, and 71 reported being in both. We received responses from 49 states, Puerto Rico, and the District of Columbia. Nevada was the only state that did not provide a response. Of all respondents, 179 were from states that have already or are planning to expand Medicaid, 49 were from states with no current plans for expansion, and 37 were in states with Medicaid expansion still pending.

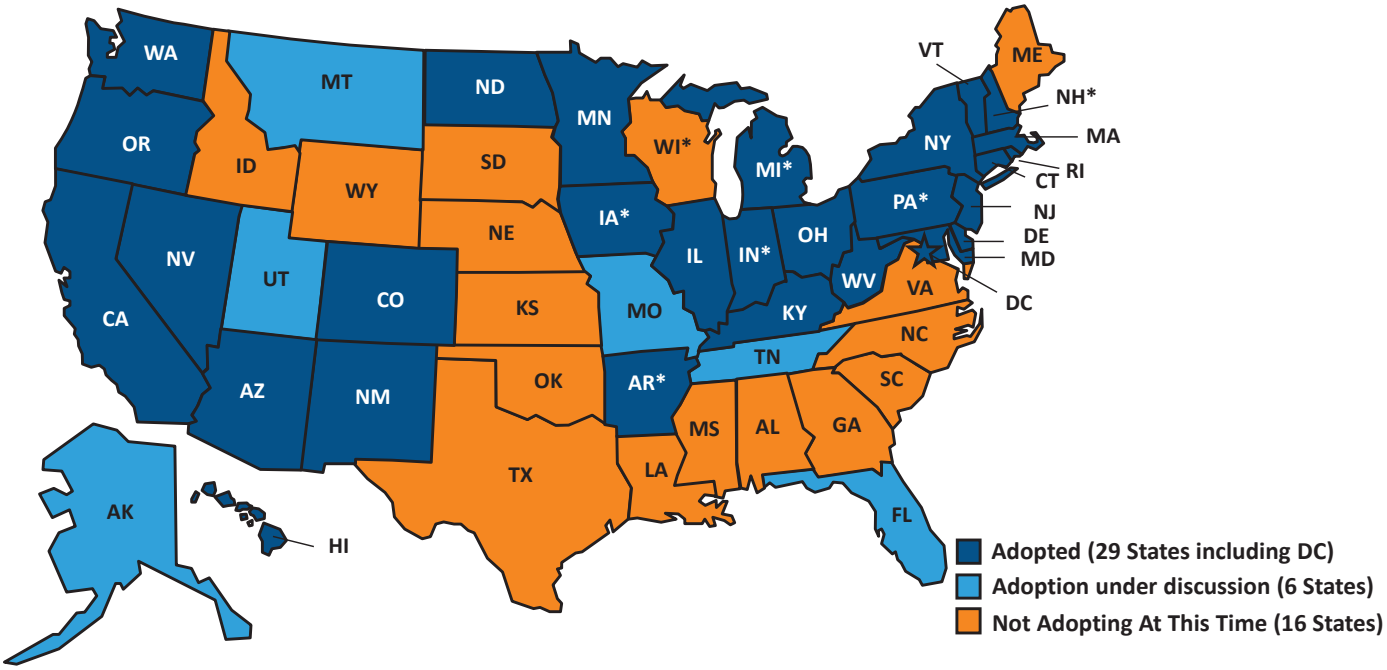
We individually solicited responses from health centers that we knew were currently undergoing or planning immediate projects, based on past engagement. Also, within the last year, the Texas Association of Community Health Centers (TACHC) completed its own assessment that contained many of the same questions. TACHC generously shared their data with us and we integrated it into our pool of respondents as

relevant, which accounted for 42 additional responses.

Once we received all responses, the data was cleaned. Capital Link's project cost report[3] was used as a source to estimate incomplete project cost data. Wherever possible, state UDS data and Capital Link-compiled industry standards were used to extrapolate projected staff increases and anticipated additional patients served.

Appendix A:

Current Status of State Medicaid Expansion Decisions



NOTES: Under discussion indicates executive activity supporting adoption of the Medicaid expansion. *AR, IA, IN, MI, NH and PA have approved Section 1115 waivers. Coverage under the PA waiver went into effect on 1/1/15, but the newly-elected governor has stated he will transition coverage to a state plan amendment. Coverage under the IN waiver went into effect 2/1/15. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated March 6, 2015. http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

THE HENRY J. KAISER FAMILY FOUNDATION

[3]Capital Link, *Estimating Capital Project Costs for Health Centers* (June, 2013)