ACCESS CAPITAL

NEW OPPORTUNITIES FOR MEETING AMERICA'S PRIMARY CARE INFRASTRUCTURE NEEDS

CAPITAL LINK
Connecting Health Centers to Capital Resources

NATIONAL ASSOCIATION OF
Community Health Centers

COMMUNITY HEALTH
VENTURES

MARCH 2008

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This report is available online at http://www.nachc.com/research-data.cfm.

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Executive Summary

At the same time that 47 million Americans are without health insurance, an even larger number – 56 million – have no regular source of primary care, because there are far too few primary care physicians in their local communities. These "medically disenfranchised" people live in every state and are disproportionately low-income and otherwise "at risk." Even more startling is the fact that many of these disenfranchised individuals are actually insured. And demand for care continues to swell.

Access to high quality primary care is an essential element to any effective and efficient health care system, and something that insurance clearly does not guarantee on its own. America's Community Health Centers have developed an aggressive new plan that charts a course for expanding their care to people currently shut out of primary health care. The ACCESS for All America plan will bridge the provider gap and bring needed and affordable health services to low-income, underserved communities. While health centers currently provide high quality primary and preventive care to more than 17 million previously underserved patients nationally, the ACCESS for All America plan will bring the benefits of health centers to 30 million patients by the year 2015 – lowering the percentage of medically disenfranchised people from 19% to 13% of all U.S. residents. The plan seeks to create a system where no one is shut out of preventive care.

The ACCESS for All America plan draws from a proven model of care that has already demonstrated significant returns to taxpayers. People who receive a majority of their care at a Community Health Center have significantly lower medical expenses – 41% lower – than those who receive the majority of their care elsewhere. This translates into a savings for the entire health care system of up to $17.6 billion annually. These savings are driven by health centers' effective comprehensive care under one roof and their success in reducing the burden on hospital emergency departments and the need for costlier forms of care. Beyond these substantial savings, investments in health centers generate $12.6 billion in economic benefits annually for their predominately low-income rural and inner-city communities through the direct employment of local residents and goods and services purchased from local businesses. If health centers reach the goals of ACCESS for All America by 2015, the savings they generate for the entire health care system could reach up to $40.4 billion annually, even as they produce $40.7 billion annually in economic activity for the low income communities they serve.

Despite the laudable benefits of health center expansion, significant investments in infrastructure are critical to meet the ACCESS for All America goals. Health centers are falling severely short in meeting their financing needs for new and renovated buildings and for health information technology. Most health centers operate in buildings more than 20 years old, with some as old as 110 years. Nearly all (94%) of surveyed health centers report that they must rebuild or renovate their facilities either to continue or expand care in the next 5 years alone. **In order to achieve the ACCESS for All America goals, health centers will need to invest $10.5 billion in facilities and equipment between now and 2015.** The current system of capital financing for health centers puts them at a considerable disadvantage. Health centers rely on government funds, foundation grants, and capital campaigns; yet these resources are scarce and insufficient to produce the necessary amount of equity to allow health centers to move ahead with their capital projects. Current capital financing programs, created over several decades when capital needs were limited and episodic, provide a patchwork of options to finance expansion; however, these programs are difficult to access, costly to implement, and extensively time consuming.

To reach 30 million patients by 2015, a new paradigm of capital financing is needed today. As this report discusses in detail, three policy requests – a federal credit enhancement program that can be married with tax-exempt bonds, dedicated tax credits to make health centers' financings economical, and a single national entity to provide streamlined access to the tax credit and tax-exempt bond markets – will allow the majority of health centers to finance their capital projects immediately. And, as documented in this report, this "new paradigm" will result in rapid expansion of health centers throughout the country.

The ACCESS for All America plan offers a path for meeting health care needs and bringing a successful system of care to millions more currently without access to these much needed services – a step that will be crucial to the effectiveness of any broad health reform initiative.

Introduction

With the political season underway, American voters must make sense of the broad sweep of proposals for fixing the U.S. health care system. Presidential candidates and, indeed, most Americans agree that our health care system is not only inequitable, but unsustainable. But limiting the debate's focus to the 47 million Americans without health insurance[1] misses the bigger picture. A far larger proportion of people living in the U.S. – **56 million** – **are struggling without access to primary health care because of a lack of providers**. The irony is that many of these "medically disenfranchised" people shut out of the health care system already have an insurance card; the problem is too few or no primary care doctors available locally to see them. The federal government anticipates that the demand for primary care physicians will increase by at least 38% from 2000 to the year 2020.[2] This emerging shortage of these physicians and other primary care providers is occurring just as the demand for preventive services takes off, the number of elderly Americans is burgeoning, and the incidence of chronic illnesses is on the rise.[3]

The trend of demand outpacing supply in primary care portends obvious hazards to public health at a time when the U.S. rate of preventable deaths is the worst among 19 other industrialized nations.[4] Few can argue against established consensus that preventive medicine is our last best hope against chronic disease, yet the political will and critical resources needed to strengthen primary care are at odds with the current budget climate. Nevertheless, investing in proven models of health care makes sense and ultimately saves federal dollars.

The national network of Community, Migrant, Homeless, and Public Housing Health Centers has a 40-plus year history of bringing critically needed health care to underserved and underdeveloped communities. Right now health centers serve as medical and health care homes for more than 17 million people across 6,300-plus sites. Health centers play a crucial national role in delivering care to a substantial volume of vulnerable populations; they serve 1 in 8 Medicaid beneficiaries, almost 1 in 3 individuals in poverty, and 1 in 5 low-income, uninsured persons. Beyond the high quality health care they provide, they bring doctors and primary care into medically underserved communities and actually save tax-payers money while generating badly needed economic activity for those same communities. Better still, most Republicans and Democrats agree that the program has proven its worth as a sound taxpayer investment, as evidenced by its top rating as one of the most highly effective federal programs by the budget-conscious White House Office of Management and Budget.[5] Demand for health center services continues to exceed the resources allocated to this important and effective program.

In their efforts to develop policies that expand access to care, policymakers must consider which providers can best serve the medically disenfranchised and other medically underserved people, and help these providers build the capacity to carry out that mission. Community Health Centers are already located in every state across the nation and are ready to address remaining unmet health care needs. They stand committed to an aggressive new plan to bridge the provider gap and directly confront the growing crisis of the medically disenfranchised. The **Affordable Comprehensive Care, Expanded to Strengthen Service (ACCESS) for All America plan** charts a course for health center growth that guides future increases in federal support for the Health Centers Program and the accompanying policy priorities necessary for continued expansion. By consistently escalating their rate of growth over the next eight years, health

centers can become medical and health care homes for nearly twice the number of patients currently served. An estimated **30 million people could have access to high quality, cost effective primary care in a health center by the year 2015**.

This great potential to make considerable gains in health care access and health care cost efficiency will require a significant investment in infrastructure. Health centers are mission-driven providers of care, serving predominately uninsured or publicly insured low-income patients. As such, they have limited and usually stretched revenue streams. To effectively alleviate the medically disenfranchised problem, health centers need sufficient resources to do so – namely, improved access to capital and to a readily available clinical workforce. Aging buildings and facilities, lack of funding to build or improve sites or transform care through health information technology (HIT), and a workforce shortage not only jeopardize their ability to meet the 2015 targets, but also threaten their ability to fully meet the needs of their current patients.

The reality is that health centers are falling short in meeting their current capital needs, which directly impacts their ability to deliver and expand care to more communities. One problem facing a growing number of health centers is that they are outgrowing their facilities. Many started operations out of small, often donated old buildings not originally designed for the provision of primary health care services, which in some cases puts limits on the efficiency of service delivery. Recent Capital Link surveys in a number of states indicate that health center facilities across the country are 22 years of age on average. About half of the health center sites in the sample had an average age of 36 years, with some operating out of buildings that are up to 110 years old. In order to grow, health centers need to construct and renovate facilities, purchase land, and invest in medical, dental, and other equipment, including HIT. Doing so lays the groundwork for building capacity to expand and maintain health center services.

This report, prepared by NACHC, Capital Link, and Community Health Ventures, documents that health centers currently need $4.4 billion to sustain, renovate, or upgrade existing facilities. Once accelerated growth is taken into account, **overall health center capital needs are in excess of $10.5 billion between now and 2015**. Unfortunately, existing resources for capital financing are slim and do not reach all health centers. This report discusses current funding available to health centers to acquire capital resources, and proposals to streamline and improve access to such capital. Workforce is also a critical need for these providers struggling to meet rising demand, and this issue will be covered in a future report. As policymakers weigh options for expanding access to needed health care, they must also address the critical infrastructure needs of safety net health care providers, including capital.

The Role of Community Health Centers in Meeting Unmet Needs

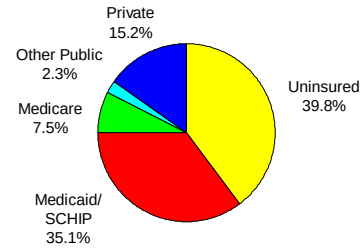
About the Community Health Center Program. The Community Health Center movement hit the U.S. health care landscape over 40 years ago, arising out of a growing recognition that millions of Americans living in impoverished communities lacked adequate health care resources. The consensus among leaders then, and now, is that health care must address the social determinants of health, including poverty, in order to improve public health.

Community, Migrant, Homeless, and Public Housing Health Centers represent a federally-designated program of health care that meets five core prerequisites set in statute. These five unique features make health centers the backbone of the U.S. primary care safety net. They must:

1. be located in a federally-designated medically underserved area or serve a designated medically underserved population;
2. have non-profit, public, or tax-exempt status;
3. provide comprehensive primary health care services, referrals, and other services needed to facilitate access to care, such as case management, health education, translation, and transportation;
4. be open to all community members, regardless of ability to pay or insurance status, and offer a sliding fee schedule that adjusts charges for care according to family income; and
5. be governed by a patient-majority community board .

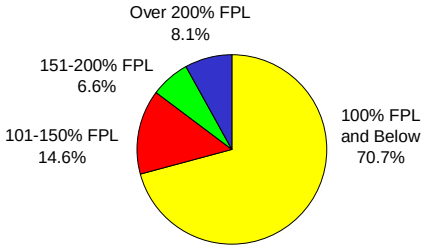
Health centers currently deliver care to **over 17 million patients** through more than 6,300 delivery sites, spanning both urban and rural communities in every state and territory. These patients are **disproportionately low-income, uninsured or publicly insured, and members of racial or ethnic minority groups** compared to the U.S. population. As Figure 1 indicates, 40% of health center patients are uninsured and 35% have Medicaid, compared to national rates of 15.8% and 12.9% respectively.[1] Most (71%) patients are in poverty whereas 12.3% of the total U.S. population are below poverty.[1] The vast majority (92%) are low-income, as Figure 2 demonstrates. Additionally, two-thirds of health center patients are racial and ethnic minorities (displayed in Figure 3), compared to roughly a third of the U.S. population who are minority.[6]

Figure 1
Health Center Patients By Insurance Status, 2006



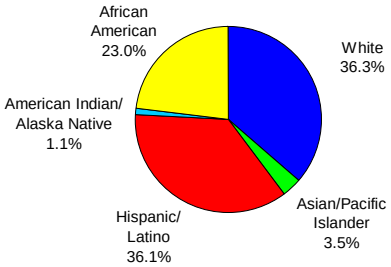
Note: Other Public may include non-Medicaid SCHIP. Percents may not total 100% due to rounding.
Source: Bureau of Primary Health Care, HRSA, DHHS, 2006 Uniform Data System

Figure 2
Health Center Patients By Income Level, 2006



Note: Federal Poverty Level (FPL) for a family of three in 2006 was $17,170. (See http://aspe.hhs.gov/poverty/06poverty.shtml.) Based on percent known. Percents may not total 100% due to rounding.
Source: Bureau of Primary Health Care, HRSA, DHHS, 2006 Uniform Data System

Figure 3
Health Center Patients By Race/Ethnicity, 2006



Note: Based on percent known. Percents may not total 100% due to rounding.
Source: Bureau of Primary Health Care, HRSA, DHHS, 2006 Uniform Data System

Related to their patient mix, health centers rely on a revenue stream made up mostly of Medicaid reimbursement (37%) and federal grants (22%). Other sources of revenue include state and local grants or contracts, foundations, indigent care programs, patient payments for services,

and third party reimbursement from other sources of insurance. **This patchwork of funding sources leaves health centers with limited resources for capital projects**.

Health Center Success. Since 1965 health centers have proven their ability to empower communities, with better health outcomes and lower health care costs. Their remarkable success has earned them broad bipartisan support among federal, state, and local policymakers. The health center model incorporates a coordinated, continuous, and patient- and community-centered focus in the delivery of a broad scope of services. These services go beyond preventive and primary medical care to include dental care, behavioral health, pharmacy services, and services that facilitate access to care, such as health education, case management, transportation, and translation. Health centers are therefore effective medical and health care homes, with a wealth of research demonstrating their success in delivering high quality care at low costs and significant savings to the national health care system. For instance, the health center model reduces health disparities, lowers infant mortality rates, and reduces chronic disease.[7] Furthermore, health center patients receive more screenings than their national counterparts for cancer, cholesterol, and diabetes, to name a few.[8]

In addition, **health centers' high quality of care generates between $9.9 and $17.6 billion in annual savings to the entire health care system**. This stems from the fact that people who receive a majority of their care at a Community Health Center have significantly lower medical expenses – 41% lower – than do people who receive the majority of their care elsewhere. These substantial savings are attributed to a host of factors, not the least of which is a reduced reliance on hospital emergency departments among patient populations otherwise marginalized from health care services. Beyond these tremendous savings, **investment in health centers also generates $12.6 billion in economic benefits annually for their predominately low-income rural and inner-city communities**, through direct employment of local residents, and goods and services purchased from local businesses. Health centers also generate more than 143,000 jobs – directly and indirectly – for local residents.[9]

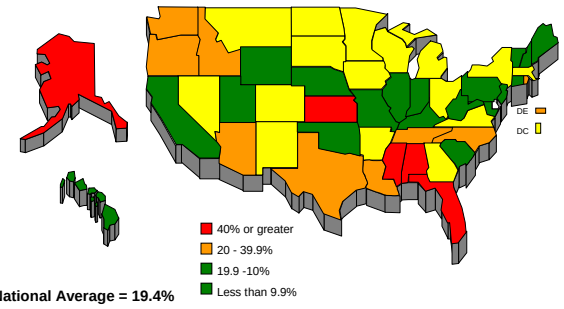
Rising Demand for Health Center Services. Clearly, health centers are a vital component of the U.S. health care system; yet health centers around the country are struggling to meet rising demand. The number of health center uninsured patients has increased 55% between 2000 and 2006. Some health centers are experiencing significantly higher increases of uninsured – as high as 73% over the same period. Meanwhile, health center patients with diabetes and those with hypertension rose 85% and 82%, respectively. Over the same time, multiple sources of health center revenue have not always kept up with the cost of care.[10] In fact, average health center operating margins are currently at 0.2%, a seven year low. Against this backdrop of growing demand and narrowing revenue sources, health centers are struggling to access capital needed for renovating facilities and building new ones to expand care. The Institute of Medicine committee that authored the 2000 report, *America's Health Care Safety Net: Intact but Endangered,* recently reconvened and noted that many health centers and other safety net providers are unable to invest in capital infrastructure because their limited resources are out of necessity focused on direct patient care.[11]

The need for health centers to reach new populations and patients continues to grow. As noted earlier, **56 million U.S. residents do not have access to primary care simply because**

there are not enough primary care physicians in their communities or the facilities to place them. The medically disenfranchised represent nearly one-in-five Americans. They **live in every state** (Map 1 below), **and many of them are actually insured.**[12] The ACCESS for All America plan to reach 30 million patients by 2015 would make a solid dent in this number. **Upon reaching 30 million patients, the number of medically disenfranchised individuals dramatically declines – from 19% to 13% of all U.S. residents**. This translates into improved access to needed preventive services by individuals left out of the health care system. Every state will also see a decline, and Map 2 below demonstrates this powerful impact. For instance, whereas 40% or more of residents in nine states are now medically disenfranchised, 40% of residents would be medically disenfranchised in just one state by 2015 – a dramatic improvement in health care access even in that one state.

Map 1

Percent of Medically Disenfranchised People By State, 2005

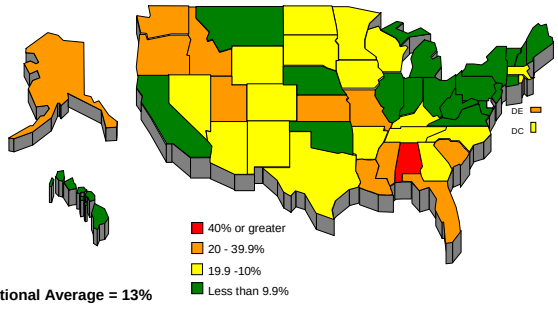


National Average = 19.4%

Source: The Robert Graham Center. Health Services and Resource Administration (HPSA, MUA/MUP data, 2005 Uniform Data System), 2006 AMA Masterfile, Census Bureau 2005 population estimates, NACHC 2006 survey of non-federally funded health centers.

Map 2

Percent of People Medically Disenfranchised Estimates By State, 2015



National Average = 13%

Source: Extrapolated findings based on 2015 state population (U.S. Census Bureau) and 2015 targets (NACHC, 2008). The Robert Graham Center. Health Services and Resource Administration (HPSA, MUA/MUP data, 2005 Uniform Data System), 2006 AMA Masterfile, Census Bureau 2005 population estimates, NACHC 2006 survey non-federally funded health centers.

What is more, once health centers reach 30 million patients by 2015, **the savings they generate for the entire health care system will reach between $22.6 and $40.4 billion that year alone**. This expansion will also **produce an additional $40.7 billion in overall economic activity**, predominantly benefiting the very communities that need this stimulus most.[9]

Current and Future Health Center Capital Needs

In the spring of 2007, Capital Link conducted a capital needs survey of health centers across the country. The purpose of the survey was to determine the current unmet capital needs of health centers in response to anecdotal reports from the field about dilapidated or outdated health center facilities hampering the current and future delivery of care. Total capital investment needs of the 245 health centers that provided project cost information amounted to $1.5 billion over the next five years with an average project cost of $6.1 million.[13]

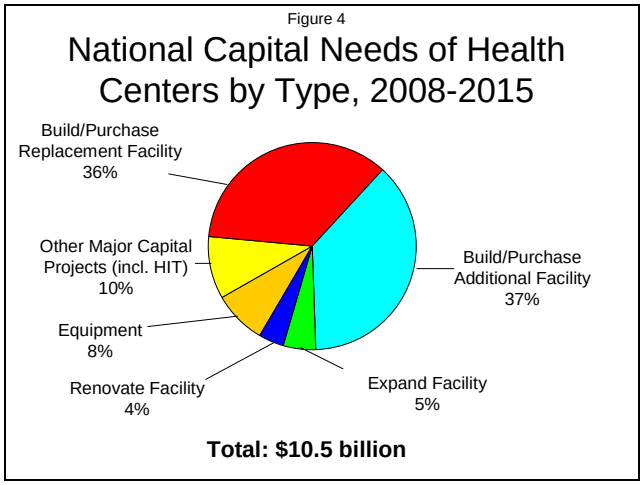
About the Survey of Health Center Capital Needs

The purpose of Capital Link's survey was to determine the current unmet capital needs of health centers nationally. Information was collected using an online survey tool that was emailed to over 900 health centers across the country. The list of surveyed health centers came from Capital Link's national database of Community Health Centers. A total of 280 health centers responded within the two week survey period. Sample health centers reported from 47 states and the District of Columbia, and had an urban/rural mix as well as a budget size distribution comparative to the health center industry as a whole, and as such can be considered a representative sample.

Almost all (94%) of the responding health centers in the national sample anticipated a need for capital investment in the next 5 years alone. Other recent capital needs surveys conducted in individual states by Capital Link indicate that two-thirds of the approximately 1,150 health center organizations across the country have unmet capital needs, and that most health centers are operating in aging buildings. Extrapolating the results of the sample group from the current survey to all health centers nationally suggests that the capital investment needs for all health centers amount to an estimated $4.4 billion over the next 5 years to sustain, renovate, and upgrade existing facilities. Urban health centers accounted for 59% ($2.6 billion) of the total current growth in capital investment needs, with an average project cost of $7.6 million. Rural health centers accounted for $1.8 billion of the total capital need and had an average project cost of $4.7 million.

Taking into account the *accelerated growth* envisioned under the ACCESS for All America health center expansion initiative, overall capital needs from 2008 through 2015 are projected to be in excess of $10.5 billion, considering additional costs for new or expanded facilities and equipment, including HIT. Figure 4[14] below delineates the different categories of health centers' capital needs. The two largest areas of need are construction or purchase of additional facilities (37% or $3.9 billion) and construction or purchase of facilities to replace existing locations (36% or $3.7 billion). Expansion and renovation of facilities account for 5% ($535 million) and 4% ($409 million), respectively, and equipment such as furniture and medical equipment makes up 8% ($872 million). Other major capital projects, especially HIT needs, account for 10% ($1 billion) of the total. This survey result is noteworthy considering that health centers report lack of capital most often when asked what barriers keep them from adopting HIT, specifically electronic medical records.[15]

Figure 4



This need for $10.5 billion in capital investment is nominal in comparison to the return on investment health centers bring to the U.S. economy and the entire health care system. Assisting health centers in meeting their capital needs will allow them to grow to serve 30 million patients by 2015 – nearly double the number currently served. This level of growth will reduce the number of medically disenfranchised Americans, not only providing improved access to needed primary and preventive services, but also **generating $40.7 billion in economic benefits to local communities and up to $40.4 billion in savings for the entire health care**

system. These economic benefits stem from the inflow of more economic activity in local communities that desperately need it, combined with the savings generated by the availability of preventive medicine for people who otherwise go without.[9]

While on average about two-thirds of health centers across the country have unmet capital needs, capital needs within a state vary, and the overall amount of financing needed may vary across states. Recent Capital Link surveys in a number of states show substantial capital needs to sustain, renovate, and upgrade existing health center facilities, including $20 million in **Arkansas**, $30 million in **Indiana**, $33 million in **Rhode Island**, $51 million in **Mississippi**, and $93 million in **Missouri**. Extrapolating these numbers to the period from 2008 through 2015 and accounting for annual construction cost inflation *doubles* the capital need in each of these states.

Current Capital Financing Support for Health Centers

Since their inception, Community Health Centers have encountered difficulty in planning and obtaining financing for the building and equipment projects that are needed to expand access to health care services in communities. Their slim operating margins, low cash reserves, complex and diverse funding streams made up of federal, state, and private monies, and lack of endowments make them "difficult credits" from a conventional lender's point of view. Health centers that have successfully funded capital projects have often done so by limiting the amount of debt they carry on a project to an amount that can be comfortably repaid with the health center's limited cash flow, thereby satisfying the concerns of lenders. As a result, most projects are funded with a relatively high proportion of "equity" and a relatively low proportion of debt. Project "equity" – generated primarily from government and foundation grants as well as capital campaigns – requires time and substantial effort to obtain, with sources in limited national supply. While more plentiful than grants, debt financing – from banks or non-profit loan funds, various government programs, and the tax-exempt bond market – is also expensive and often cannot be obtained until the requisite equity funding is largely in place. As a result, health centers often take many years to cobble together multiple sources of funding for a single project. During this lengthy and complicated process, project costs invariably escalate, further exacerbating the challenge of raising the needed capital. In the end, the process often results in higher-than-warranted interest rates, inflated transaction costs, and terms that are less than advantageous.

Ultimately, in order to meet rising demand for services as well as grow the federal Health Centers Program to 30 million patients by 2015, financing for facilities and HIT must be made more accessible at reasonable rates, costs, and terms, and the process must be streamlined and made more cohesive to allow projects to progress at a faster pace. Current capital financing programs, created over several decades when capital needs were limited and episodic, provide a patchwork of options to finance expansion; however, they require a certain degree of sophistication to obtain and are scarce and time consuming. To reach the 2015 goal, a "new paradigm" of capital financing is needed today. Our proposed new paradigm, detailed later in this report, would dramatically improve health center access to capital by consolidating financing services into a single, functioning system accessible to any health center that needs it.

Table 1 below provides a brief overview of the major federal programs and other sources of capital on which health centers currently rely to fund their capital needs. A more detailed description of each of these programs and several other programs that are no longer available is included in Appendix A. Appendix B provides examples that illustrate how health centers have used many of the funding sources described here to fund their capital projects.

For almost two decades, the major source of health center "equity" funding for capital projects came from the *Health Resources and Services Administration's* (HRSA, the agency that oversees the Health Centers Program) authority to allocate a small portion of the federal Section 330 health center appropriation on a competitive basis to health centers for construction projects. This *health center construction authority* was repealed in 1996 and replaced with a *loan guarantee backed by HRSA*. Under this program, all federally-funded health centers are eligible for loan guarantees of up to 80% on the principal amount of loans made by private lenders to health centers for their capital projects. Rural health centers are also eligible for a more advantageous loan guarantee program, as well as direct loans and even some capital grants, through the *U.S. Department of Agriculture (USDA) Rural Community Facilities Loan Programs.* Both the HRSA and USDA guarantee programs are of limited value to health centers because the guarantees cannot be used with *tax-exempt* debt. This limitation deprives health centers of access to the lowest cost capital available in the market, and requires them to raise a larger proportion of their capital costs through capital campaigns in order to afford the higher cost debt.

Only recently have health centers found new and creative ways to use the HRSA loan guarantee, specifically utilizing it in conjunction with *New Markets Tax Credits* (NMTC). NMTC offers tax credits to investors who choose to invest capital in distressed areas, including those communities served by health centers. This effective program has enabled health centers to borrow at very low cost, while also providing a means to fill the equity gap that health centers often struggle to fill. The NMTC program has its drawbacks, among them a limited supply of tax credits and a cumbersome process riddled with strict eligibility requirements and multiple tax credit suppliers. Yet NMTCs have increased the use of the HRSA loan guarantee program, using up a significant amount of the $160 million allocated for loan guarantees.

Table 1.
Current Health Center Capital Financing Support

Sources of Capital Funding	Years in Operation	Eligibility	Benefits	Limitations
Health Resources and Services Administration Loan Guarantee Program, DHHS	1996-present Replaced Construction Authority.	All federally-funded health centers	Provides a guarantee of up to 80% of the principal amount of loans made by non-federal lenders. In some cases, this slightly lowers capital costs or provides collateral for loans that would not otherwise meet lender requirements. Can be used in conjunction with New Markets Tax Credits.	The rate of guarantee is not as high as the USDA's loan guarantee program. Cannot be used with tax-exempt bonds, which means that the presence of these guarantees does not significantly lower the interest rate to health centers.
Rural Community Facilities Loan Programs, U.S. Department of Agriculture	1974-present	Rural health centers located in communities of up to 20,000 residents	The *Direct Loan Program* offers direct loans up to about $1 million to eligible borrowers at low rates. The *Guaranteed Loan Program* offers loan guarantees of up to 90% on loans or taxable bonds. The *Grant Program* covers up to 75% of a capital project's cost.	Excludes urban health centers and health centers in rural areas with populations above 20,000. The *Guaranteed Loan Program* cannot be used with tax-exempt bonds, thus limiting its effect on lowering interest rates to health centers. The *Grant Program* prioritizes the smallest and poorest communities, and grants tend to be small.
Federal Appropriations (Earmarks)	Ongoing	As determined by individual Members of Congress	Currently this is the only substantial source of federal grant funding available for health center capital projects.	Funding decisions are based on political considerations and the degree to which a willing Member of Congress can influence the appropriations process, not necessarily based on the need for or merits of a project.
Private sector loans, Available through banks or non-profit loan funds	Ongoing	Any health center with a strong enough credit history	Local lenders may have ties to individual health centers and may support their capital activities through conventional loans. Non-profit or public purpose loan funds may have better loan terms and may sometimes approve loans that a typical commercial lender might refuse.	Financing is usually market rate and for relatively short terms (usually 5 to 7 years, with longer amortizations).

Sources of Capital Funding	Years in Operation	Eligibility	Benefits	Limitations
Tax-Exempt Bonds	Ongoing	Non-profit entities (including most health centers)	Offers health centers access to capital with very low tax-exempt interest rates and longer terms, thereby enabling health centers to carry a larger loan and consequently reducing the amount of upfront equity necessary for the project.	Most tax-exempt bonds require credit enhancement to obtain advantageously priced capital. Health centers have rarely been able to access the private credit enhancement market and lack a federal credit enhancement program that can be used with tax-exempt bonds. Upfront costs are considerably higher than standard commercial loans.
New Markets Tax Credits (NMTC)	2000-present	Most health centers qualify because of their locations	Enables health centers to borrow at very low cost, while also providing a component that acts as "near equity," thereby helping to fill the equity gap experienced by most health centers. Can be used in conjunction with the HRSA loan guarantee program, allowing centers to achieve a lower interest rate for the debt portion of their financing.	Tax credits are in short supply and are only available through a decentralized and ever-changing list of Community Development Entities (CDEs) that are awarded tax credit allocations by the US Department of Treasury. Few CDEs have experience working with health centers, and those that do often have very limited allocations. The result is a very time consuming and expensive process, often requiring health centers to work with multiple CDEs to obtain enough tax credits to benefit their projects.

A National Capital Campaign for Health Centers

As illustrated by the examples in Appendix B, individual health centers have been modestly successful in pulling together multiple sources of capital to fund their projects. However, the cost, complexity, and time needed to raise this capital demonstrates that achieving the ACCESS for All America goal of 30 million served by 2015 will not be possible without significant improvements to the capital financing mechanisms available to health centers. Indeed, the need for these improvements is even more pressing now, in the face of the sub-prime mortgage crisis and the resulting tightening of credit and credit enhancement requirements on all levels. In the context of the current credit environment, health centers continue to encounter barriers to meeting *existing* capital needs, much less the capital needs associated with a dramatically expanded health center system. In order to support ACCESS for All America goals, **health centers need a national capital finance structure that will allow them to access low cost funding through a predictable, swift, and streamlined process, thereby enabling more rapid expansion**.

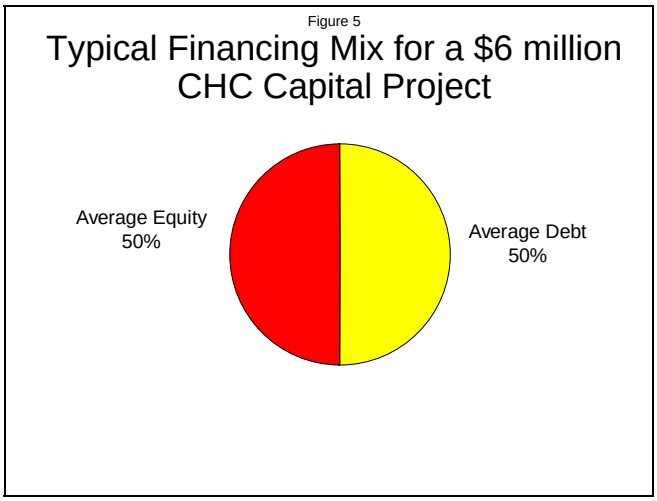
What might this new structure look like? It would include the following three components, together with increased technical assistance to health centers for their capital development:

1. a federal credit enhancement source that can be used in conjunction with tax-exempt bonds;
2. a tax credit allocation specifically for health centers; and
3. a single national entity to provide streamlined access to the tax-exempt bond market and facilitate the use of tax credits.

The following narrative provides the rationale and thought process behind this new paradigm and offers recommendations on how to build on current programs in order to rapidly expand the Health Centers Program.

First, the new paradigm starts with an acknowledgment of a basic reality for health centers: they have limited cash available for debt service. Higher interest rates mean health centers can support less debt; lower interest rates mean that they can support more debt *with the same cash flow*. Building on this concept, and on data developed and maintained by Capital Link, consider the situation of an "average health center" with an average size capital project of $6 million. Currently, the average health center funds its capital project with 50% equity, comprised of grants and contributions and 50% debt, assuming interest rates of 7% over 20 years.[16] The funding mix for a $6 million project therefore looks like Figure 5 below.

Figure 5

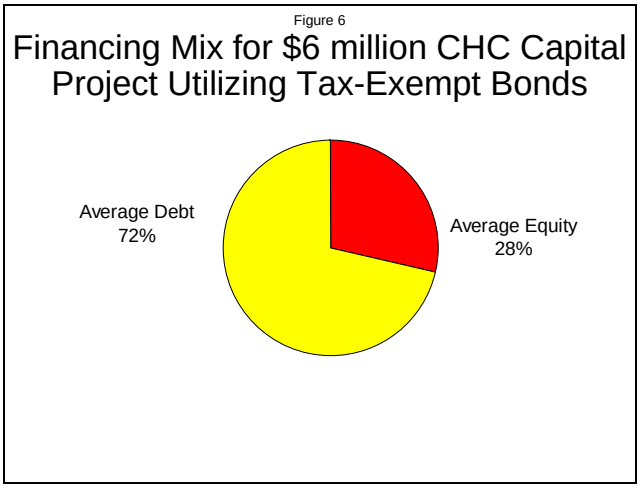


An analysis of a representative sample of health center audited financial statements suggests that under this financing scenario, less than half of all health centers can afford a loan of approximately 50% of their project costs under these conventional rates and terms – and still face the difficult prospect of raising the other 50% to pay for the balance of their capital project costs. Given that less than 10% of health centers have demonstrated the capacity to raise more than $500,000 in a given year in capital campaign contributions,[17] the data suggest that the average health center will require at least 5 years of fundraising to generate the equity that would be necessary to fund 50% of an average project.

Recommendation #1: A Federal Credit Enhancement Source That Can Be Used With Tax-Exempt Bonds. Tax-exempt bonds offer significantly lower rates than those available in the conventional debt market. Health centers that finance their projects with tax-exempt debt can afford to support a larger loan, in much the same way as a home owner can "afford more house" when interest rates decline. For example, the identical debt payments associated with the $3 million conventional debt example above can support a loan of $4.3

million, assuming tax-exempt interest rates at 5% and a 30-year amortization. In effect, lowering the interest rate stretches the health center's debt service dollars farther and thereby reduces the *amount* that must be raised from grants and the *time* required to raise these funds. If tax-exempt bonds were readily available to health centers, a typical financing mix for a $6 million project would look like Figure 6 below.

Figure 6



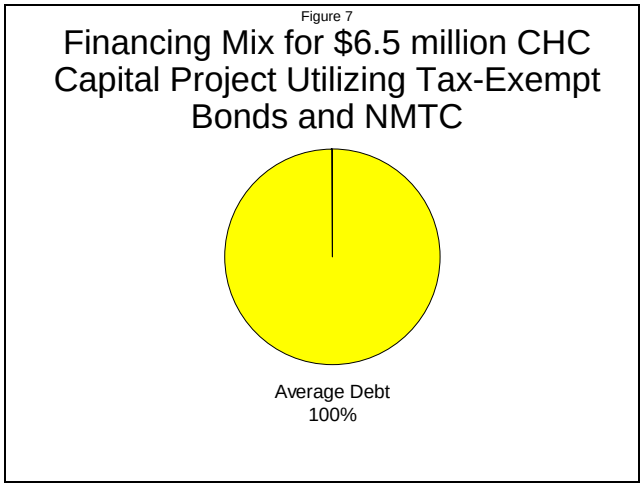
Because of the decreased amount of equity from grant or capital campaign dollars necessary for the project, the average health center could accelerate its capital development processes by approximately 2 years, but it would still require an average of 3 years for the average health center to raise the necessary equity. However, **in order to access the tax-exempt bond market, health centers would also need access to a consistent source of high quality credit enhancement** – such **as bond insurance or a highly-rated letter of credit – a virtual requirement for these issuances**. Unfortunately, health centers do not have access to federal credit enhancement that can be used with tax-exempt bonds. However, one little used and currently inactive program, the Department of Housing and Urban Development (HUD) mortgage insurance program, could be revived for such a purpose. In 1966, Congress amended the National Housing Act[18] to include Title XI, "Mortgage Insurance for Group Practice Facilities." Title XI defined Group Practice Facilities as facilities "for the provision of preventive, diagnostic and treatment services to ambulatory patients by a medical or dental group." The program provided federal mortgage insurance on loans made through HUD-approved lenders. This mortgage insurance program is one of the very few federal programs authorized for use with tax-exempt bonds.

Because of changes in the health care marketplace, the "Group Practice Facilities" that were the intended beneficiaries of this program never proliferated in a manner consistent with the program's requirements. In particular, the program required that borrowers be organized on a non-profit basis. Given that the private group practice model that developed in the U.S. was predominantly for-profit, this program did not match the needs of the market. As a result, between 1968 and 1980, only 26 mortgages were insured under Title XI, and none were to health centers. In the last 28 years, no Group Practice Facility mortgage has been insured under the Title XI program.[19]

Ironically, at approximately the same time this group practice mortgage insurance program was established, Congress also passed legislation authorizing the federal Health Centers Program, which funded non-profit entities that exhibit many of the features of the group practice model promulgated by this mortgage insurance program. The problem, however, was that the two programs were like the proverbial "ships passing in the night" – neither one saw the other, so intent were they on achieving their final destinations. Now, given the urgent need of health centers to access lower-cost forms of capital, the program offers a tantalizing opportunity to revive, modernize, and reshape the program in a manner that could profoundly alter the ways health centers access capital for the foreseeable future. In particular, to offer the highest use to health centers, the program should be retooled so it can be paired with federal tax credit programs in a streamlined manner, as further discussed below. U.S. Senators Stabenow (D-MI) and Cochran (R-MS) have offered legislation (Community Health Center Capital Investment Act (S.2270)) that would begin the process of revitalizing and revising this program for the benefit of health centers.

Recommendation #2: A Tax Credit to Spur Health Center Development. Tax credits, such as those available through the federal New Markets Tax Credit (NMTC) and Historic Tax Credit (HTC) Programs, can serve as equity or "near equity" for eligible projects, effectively filling the gap between the costs of a project and the amount of debt that a borrower can support. Though tax credit structures vary, in a typical leveraged NMTC structure available in the market today, the same cash flow needed to service a $3 million loan at conventional rates and terms could instead support $6.5 million in debt funded with tax-exempt bonds in conjunction with New Markets Tax Credits. Thus, with access to tax-exempt bonds and tax credits, the financing mix for a typical health center capital project would look like Figure 7 below.

Figure 7



If widely available to health centers, this mix of financing vehicles would serve as the building blocks for the new paradigm of financing that health centers need. In this case, one can see that it can be used to fund the entire cost of an average $6 million capital project. It can create the flexibility to fund HIT projects at the same time. Or alternatively, it would allow the health center to lower the amount of its annual debt service payments and use the savings to hire doctors or invest in programs and services for patients. To date, at least 15 health centers

nationally have utilized the New Markets Tax Credit program (and in some cases the Historic Tax Credit Program as well), generating significant "near equity" resources and low cost loans for projects totaling approximately $160 million. Though each transaction was structured in a unique manner to meet the needs of the individual health center, for the most part they included a loan component with nominal interest-only payments for seven years. This loan component, equal to approximately 25% of the project costs, functions as "near equity" in the transaction. This "near equity" component essentially bridges the gap between the amount of conventional debt the health center can afford and the project's cost, thereby eliminating much of the need for fundraising and allowing projects to proceed that would not otherwise have been financially feasible.

If health centers had access to the tax-exempt bond market, buttressed by federal credit enhancement, and to tax credits on a consistent basis as part of a consolidated one stop shopping system, Capital Link estimates that at least 57% of health centers nationally would be able to finance their capital projects *immediately* with this mechanism, without having to spend years raising funds through capital campaigns.[20] Many others would be able to follow suit within two to three years, after completing more limited fundraising campaigns. In combination, tax-exempt bonds and tax credits hold the promise of dramatically improving health centers' abilities to access the capital needed to grow to serve 30 million people by 2015. For an example of how this financing paradigm worked for one health center, Fenway Community Health Center in Boston, see Appendix C.

Recommendation #3: A National Entity to Facilitate Financings for Health Centers. One of the significant challenges of tax-exempt bond and tax credit financings for health centers is the fragmented nature of the systems involved in executing these financings. As the Fenway Community Health Center example suggests (Appendix C), the sheer number of entities that were involved in assembling the capital necessary for the project (two Community Development Entities with tax credit allocations, a tax-exempt bond issuing authority, a letter-of-credit bank, an underwriter, a NMTC investor, bond purchasers, accountants, and the attorneys representing all parties) created an unnecessary level of complexity and additional costs to obtaining financing. To remedy this situation, Congress could authorize a single national entity to issue tax-exempt bonds on behalf of health centers, utilizing federal mortgage insurance available through a revitalized and retooled HUD mortgage insurance program. Ideally, this same entity would have access to federal tax credits equal to 30% of the eligible projects' costs as well. Centralizing these capital-raising functions in a national entity would greatly streamline the process, create economies of scale and additional savings in issuance costs, and establish a reliable and discernable path toward readily available capital to speed health centers' needed expansion.

More importantly, for this new paradigm to work successfully, health centers must have available to them increased technical assistance for their capital development projects. Even with a revitalized HUD mortgage insurance program to be used in conjunction with tax-exempt bonds, a dedicated allocation of tax credits to fill the equity gap and a single national entity to streamline the process, it is still incumbent upon health centers to undertake rigorous business and capital planning processes so that their proposed expansion projects can demonstrably meet the vital health care needs of their communities in a fiscally prudent manner. Indeed, to protect

the federal government's significant investment in the Health Center Program and in the financing mechanisms envisioned in this report, it will be critical to ensure that the projects slated for development are of the highest possible quality in every respect.

Over the past ten years, the federal government has made available a limited amount of capital-related technical assistance to federally-funded health centers. In order to allow health centers to grow at the rapid pace envisioned by the ACCESS for All America plan, a further investment in expanding the availability of these technical assistance resources would be prudent and necessary to achieve success.

What Would This "New Paradigm" Cost? This proposed new paradigm to transform health center access to capital will cost far less than the savings to the health care system that will be achieved through a rapid expansion of health centers throughout the country. Assuming that health center capital needs equal $10.5 billion over the next eight years, and that Congress 1) establishes or revitalizes a federal credit enhancement program that can be used with tax-exempt bonds, 2) dedicates federal tax credits for up to 30% of health center eligible capital project costs, and 3) establishes a national entity to coordinate the two programs in a seamless manner, **the federal investment would total approximately $3.5 billion[21] between now and 2015 to assist health centers in meeting their capital needs and to allow them to grow sufficiently to serve 30 million people in 2015**. However, as noted earlier, health centers already save the health care system many billions more than they cost each year, and **those savings would equal between $133.3 billion and $237.1 billion over the eight year period, dwarfing the cost of the new paradigm required to facilitate the needed expansion**. In addition to these savings, the expansion of health centers will also stimulate the local economies in which the health centers are located, both in terms of jobs and economic stimulus associated with the construction projects themselves and the economic boost generated by the ongoing presence of the health centers in their communities.

Current Legislative Initiatives to Improve Health Center Access to Capital

NACHC is currently working with Congress to implement a number of legislative initiatives designed to improve access to capital and increase low cost debt financing options. Two bills were recently introduced in the Congress to address specific policy issues identified in this report. While these initiatives alone are not sufficient to solve all the capital access challenges that health centers face, they represent key steps in the right direction.

Build, Update, Improve, Lift, and Design Health Centers Act (S. 1990). The BUILD Act establishes a competitive grant program that allows health centers to use federal funds for facility modernization, expansion, construction, and major purchases. Sponsored by Senator Rockefeller (D-WV), this legislation will allow HRSA to use 5% of the health center appropriation for capital grants and for federal loan guarantees to be used for health center capital projects, in order to advance health center facility and equipment goals.

Community Health Center Capital Investment Act (S. 2270). Although both USDA and HRSA Loan Guarantee Programs give health centers a financial boost, acquiring debt financing remains an uphill struggle. This bill proposes to resurrect and reinvigorate an obsolete federal mortgage insurance program for the benefit of health centers. Sponsored by Senators Stabenow (D-MI) and Cochran (R-MS), the bill would make health centers eligible to use a HUD federal mortgage insurance program to provide credit enhancement for their capital projects. This particular mortgage insurance program can be used with tax-exempt bonds, and as such, would be particularly beneficial for health centers because of the lower interest rates available through the tax-exempt bond market.

Conclusion

With rising numbers of U.S. residents with unmet primary care needs, the ACCESS for All America health center expansion plan is a critical building block for strengthening and expanding our nation's primary care infrastructure for now and for generations to come. Access to primary care is our best defense for protecting the nation's public health; yet too many uninsured, underinsured, and even insured people are colliding against increasing barriers to care. Imagine a health care system in which all Americans have access to comprehensive primary health care, regardless of their ability to pay, while at the same time the overall cost of health care actually *goes down*. Upon reaching the 30 million patient target in 2015, the number of U.S. residents without access to primary care because of physician shortages – the so-called "medically disenfranchised" – will decline from 19% to 13% of all U.S. residents, while the savings that health centers reap for the health care system could grow to $40 billion annually. Community Health Centers stand ready to make a huge impact on the problem of medical disenfranchisement and underservice in general, with the necessary investments to allow them to do so.

The fate of the ACCESS for All America goal rests partly on the availability of $10.5 billion in capital financing. Health centers currently contend with a hodge-podge of disjointed capital assistance programs that either leave some health centers ineligible or some capital needs unmet. The impact of this shortfall on health care delivery is tangible. Without, for instance, a sufficient number of patient exam rooms at a health center, fewer patients are treated and more are left to languish. Without dental exam rooms, oral health problems go untreated. To create more medical and health care homes, health centers, quite simply, require the means to build them. The current fragmented system is too cumbersome and costly to work. What is needed is a new capital financing paradigm, that is, a single source through which access to low cost debt and equity funding is possible through an unfettered, streamlined process. Only then can a rapid expansion of health centers be carried out.

More importantly, building the capacity of current and future health centers requires a significant investment in both capital *and* workforce. Health centers currently experience a significant shortage of clinicians,[22] and the effect of this shortage will hamper health centers' ability to reach more patients with unmet needs even if new and expanded health center sites are built. The special challenge of workforce shortages will be covered in a separate report due out this August, prepared jointly by NACHC and the Robert Graham Center.

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[13] Figures include estimated annual construction cost inflation factor of 7%; based on Associated General Contractors Inflation Report, September 2006.
[14] Assumptions for Figure 4: (1) 1,700 New Access Points (NAP) added 2008-20015 (NACHC); (2) 60% of NAP with Capital Project; (3) Median NAP Capital Project Cost National Sample 2007 is $2,000,000; (4) 128 NAP Capital Projects per year, 2008-2015; (5) 800 Expanded Medical Capacity Grants (EMC) added 2008-2015; (6) 30% of EMC with Capital Project; (7) 30 EMC Capital Projects per year, 2008-2015; (8) Median Expansion Project Cost National Sample 2007 is $750,000; (9) Equipment Costs as percentage of build replacement/ additional facility or expanded facility is 15%; and (10) Annual HIT Equipment Inflation Factor is 3%.
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[16] Based on an analysis of health center capital projects completed with Capital Link assistance.
[17] Based on an analysis of health center audited financial statements compiled and maintained by Capital Link.
[18] 12 U.S.C. 1701
[19] U.S. Department of Housing and Urban Development. "Barriers to the Receipt of Mortgage Insurance by Federally Qualified Health Centers." August 2004. The Hospital Mortgage Insurance Act of 2003 directed HUD to conduct this study.
[20] Based on an analysis of audited financial statements from a sample of 222 health centers within Capital Link's Health Center Financial Trends Database.
[21] This cost estimate assumes that health centers realize $3.15 billion in benefit from sale of tax credits and $7.35 billion in tax-exempt bonds issued through 2015. Assumes a credit enhancement cost to users of .5% on total debt service – consistent with HUD's Hospital 242 Mortgage Insurance Program. Total debt service is assumed based on a thirty-year financing with interest rates at 5%. This mortgage insurance program has a net savings to the government because payments from borrowers exceed the cost of the program. No assumption has been made for loan losses, given the 40-year history of the Health Center Program and its negligible default history.
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Appendix A
A Detailed History of Health Center Capital Financing Support

The following provides background on major, national programs that have helped Community Health Centers meet their capital needs over the years.

Health Center Construction Authority. Between 1978 and 1996, the major source of equity funding for health center capital projects came from the federal government. Prior to 1978, health centers could not use their federal Section 330 grant dollars for construction, modernization, and renovations. That year, when the program was reauthorized,[1] a new subsection was added, authorizing health centers to utilize a portion of their federal grants for their physical buildings. The delicate compromise at the time, which stood until 1996,[2] was that federal grant funding could be used for any reason, but federal prevailing wage laws (commonly referred to as "Davis-Bacon") would specifically apply to modernization and renovation projects. The prevailing wage law would not apply to health center funds for construction. This provision lasted until 1996, authorizing use of a small portion of Section 330 funds for the Capital Improvement Program (CIP).

The Health Resources and Services Administration Loan Guarantee Program. In 1996, during Congressional consideration of legislation to reauthorize the federal Health Centers Program, the entire construction authority section was dropped to fulfill the new Republican majority's goal of removing prevailing wage rate requirements from all federal construction program authorities. The loss of construction authority and its impact on health centers was not lost on some Members of Congress. Consequently, a new compromise was struck: the federal government would guarantee loans made to health centers for capital projects.

The new loan guarantee program was seen by many as a way to lower the cost of financing capital projects, and since health centers could continue to use their federal grant funds for loan payments, the guarantee would still save the center money. With this in mind, Congress appropriated $7 million in FY1997, and an additional $8 million in FY1998, into a special Loan Guarantee fund to provide credit support for health center loans made by private lenders. The loan guarantee program was established within the Health Resources and Services Administration (HRSA), the agency that oversees the Health Centers Program. Indeed, the $15 million in appropriated funding generated a total of $160 million in loan guarantee authority for capital projects. Similar to the U.S. Department of Agriculture (USDA) guarantee program discussed below, eligible costs associated with loan guarantee-funded projects include land and building acquisition, renovation and new construction, necessary equipment for the building, and other costs.[3] Administered through the HRSA Bureau of Primary Health Care, this program is open to all federally-funded health centers meeting loan guarantee program requirements, whereas the USDA program is only open to rural health centers.

Unfortunately, severe restrictions on the HRSA loan guarantee have limited its usefulness to health centers. Current federal policy[3] limits the HRSA loan guarantee to 80% of the total principal amount, while the USDA guarantee can cover up to 90% of principal and interest. More importantly, neither of these guarantees can be used with tax-exempt bonds, which means

that the presence of these guarantees does not significantly lower the interest rate for health centers.

The HRSA guarantee has mainly been most useful in circumstances in which the appraised value of the site falls below bank lending standards. Only recently have health centers found new and creative ways to use the HRSA guarantee, utilizing it in conjunction with New Markets Tax Credits (discussed below). This innovative pairing has helped the guarantee program realize its potential and has increased its use to the extent that nearly all of the $160 million in available loan guarantees has been allocated. Thus, unless additional funding is set aside to guarantee additional loans, the current guarantee program will be fully-obligated and unavailable for additional financings.

Facilities Construction Under the Hill-Burton Act. In response to evidence of an extensive shortage of adequate hospital facilities around the country but mainly in rural areas, Congress passed the Hospital Survey and Construction Act in 1946, thereby amending Title VI of the Public Health Service Act. The bill is commonly known by the names of the legislation's initial sponsors, Senators Lister Hill of Alabama and Harold Burton of Ohio, thus named the *Hill-Burton Act*.[4] The bill provided federal assistance for the construction and improvement of hospitals and eventually other health care facilities, such as clinics. It authorized states to inventory existing hospitals in order to assess which facilities provided adequate care and services to community residents. Hill-Burton also authorized funds to assist states with the construction of public and non-profit hospitals in areas lacking adequate facilities. Specifically, this bill provided resources to build new facilities and to expand, renovate, and change existing ones.[5]

In 1975, Congress amended Hill-Burton to make three specific types of capital aid for facilities construction or modernization available to health centers, hospitals, and other eligible facilities. These included grants, direct loans, and loan guarantees to non-federal lenders, all provided under Title XVI of the Public Health Service Act. Facilities receiving any of these three are obligated under Hill-Burton to provide an annual minimum dollar value of uncompensated care. The length of time the facility has to provide this care varies depending on when aid was received, ranging from 20 years to a perpetual requirement.[5] Although the Hill-Burton Program stopped providing funding in 1997, facilities that once received funds are still obligated to provide care for those whose incomes are at or below the federal poverty line.[4] Not covered under the Hill-Burton Program are private physician fees, pharmacy fees, and Medicare deductibles and copayments. Unique within this bill is the requirement that the facility must present its plan of free or reduced costs of care in the local paper as well as provide patients with the information upon arrival to the facility.[5]

As of February 2008, roughly 239 facilities were obligated under the Hill-Burton Program to provide care to patients at reduced or no cost. Of those facilities, at least 24% were health centers.[6] Hill-Burton provided a total of over $53 million to these centers.[7]

U.S. Department of Agriculture Rural Community Facilities Loan Programs. Probably the most significant sources of capital support for rural Community Health Centers over the years have been the U.S. Department of Agriculture (USDA) Community Facilities

Loan Programs (CFLP), which are geared towards generating economic development in rural areas.[8] These programs target communities of up to 20,000 residents and offer direct loans, guaranteed loans, and (to a small extent) grants to community health services, schools, libraries, and fire, rescue, and police stations. Health centers, as well as municipalities, tribal governments, and other non-profits, are eligible for these programs. The USDA programs have proven very helpful to rural health centers, but the population limitations on all USDA programs have hindered many health centers in more densely-populated rural areas from accessing these useful programs.

CFLP loans can be used to fund construction, additions or enlargements, renovations, and equipment costs for facilities used for health care, public safety, and public services. Authorized in 1974, the *Community Facilities Direct Loan Program* offers direct loans to eligible borrowers at rates ranging from 4.5% for high poverty rural areas to the prevailing market rate, fixed for 30 years. These terms rival rates available in the tax-exempt bond market, without the upfront costs generally associated with tax-exempt bonds. This excellent program became especially important for health centers as a result of a memorandum of understanding between HRSA and USDA in 1977, setting aside $35 million annually in USDA's CFLP funds for rural health centers. While this agreement ended in 1990, the program remains a significant, if dwindling, resource for rural health centers today. In FY 2007, USDA loaned almost $354 million, including more than $149 million for health facilities. Only 26% of that amount went toward primary care projects.

Authorized in 1992, the *Community Facilities Guaranteed Loan Program* offers rural health centers and other eligible entities loan guarantees covering up to 90% on any loss of interest or principal on loans or bonds. The USDA increasingly prefers loan guarantees over direct loans because loan guarantees offer a better "multiplier" effect that allows the USDA to serve more rural communities seeking to develop essential facilities. On average, a project in the Guaranteed Loan Program runs about $2 million.[9] The USDA Guaranteed Loan Program has grown in recent years and guaranteed more than $228 million in loans in FY 2007. Unfortunately, of that amount, only 15 loans for primary care facilities totaling $20.7 million were guaranteed. Though this guarantee program can be useful in some cases (and is better in certain ways than HRSA's guarantee), it is much less favorable to health centers than USDA's Direct Loan Program. Like HRSA's Loan Guarantee Program, it cannot be used with tax-exempt bonds and therefore has a limited effect on lowering the interest rate for health centers.

USDA also has a small *Communities Facilities Grant Program*, which serves the same types of rural communities, organizations, and eligible projects as its loan programs. However, these grants prioritize communities with fewer than 5,000 residents and where median household income is low, as well as projects under special initiatives. Grants are often made in combination with funding from other sources, including Community Facilities Direct and Guaranteed Loans. Communities Facilities Grants are available for up to 75% of a project's cost, and final amounts depend on the local community's population and median household income, as well as availability of funds.

Unfortunately, funding for these direct grants has dwindled even as competition increases. In FY 2007, 1102 projects were awarded a total of just more than $56 million. Of that

amount, only 20 primary care-related projects received funding totaling slightly more than $1.6 million. Increasingly, USDA provides grants only to the neediest applicants – often those with little or no capital available. Although this has helped some of the poorest health centers, many more are left to raise capital via expensive and time consuming capital campaigns.

Changing Landscape of Financing. Limits on the use of health centers' federal grant funding for construction and patchy federal direct loan and guarantee programs compel health centers to seek capital resources not only in the private market, but also from Congress directly. While loan guarantee programs offer some relief for health centers seeking debt financing, they do not address the loss of direct capital support from the federal government. To meet this need, health centers have been forced to reach out to their individual Members of Congress for annual *earmarks* to provide desperately needed capital. Although a number of health centers have received funding, this process has been time consuming and yielded inconsistent results for health centers. Unfortunately, many projects receive funding based on their political representation rather than the health care needs of the community.

As grant support for health center capital projects has dwindled, the need for the lowest cost debt financing available has become even more important. To this end, a few health centers have worked to access the complex *tax-exempt bond market*. As non-profit, 501(c)(3) entities, most health centers can qualify to receive tax-exempt bond financing issued through bonding authorities known as conduit issuers. Tax-exempt bonds can offer health centers access to capital with very low interest rates and longer terms, thereby enabling health centers to afford to carry a larger loan and consequently reducing the amount of upfront equity necessary for the project.

However, though tax-exempt bonds can benefit some health centers, they also pose a number of challenges. Obtaining credit enhancement through a letter-of-credit or bond insurer is a virtual prerequisite for bond financing. Unfortunately, health centers do not have access to a federal credit enhancement program that can be used with tax-exempt bonds, and most health centers cannot meet the credit criteria of the private credit enhancement market. Because of the complexity of bond financing, the upfront costs are considerably higher than standard commercial loans. In addition, bonds are issued by numerous issuers at the state and county level. Some states have multiple bond issuers while others may have none. Consequently, health centers must spend time researching whether bond options are available and, in some cases, choosing which issuer to use. As a result of this decentralized framework, the few centers that access the tax-exempt bond market must do so through a myriad of financing arrangements with issuers across the nation, and best practices often do not translate across state lines.

In 2000, Congress initiated the *New Markets Tax Credit* (NMTC) program to direct investment into low-income communities. The program offers tax credits to investors who choose to invest capital in distressed areas. Because health centers are frequently located in high-need areas, they are strong candidates for NMTC financing. This effective program has enabled health centers to borrow at very low cost, while also providing a subsidized debt component that acts as near equity, thereby helping to fill the equity gap experienced by most health centers. In a number of cases, health centers have used the NMTC program in conjunction with the HRSA loan guarantee program. Using this combination, health centers

have been able both to increase the amount of equity available to the project *and* achieve a lower interest rate for the debt portion of their financing.

The only drawback to the NMTC program for health centers is that the tax credits are in short supply and are only available through a decentralized and ever-changing list of Community Development Entities (CDEs) that have been awarded tax credit allocations by the U.S. Department of Treasury. Only a few of the CDEs with allocation have any experience in working with health centers, and those that do have experience with this industry often have very limited allocations available to them. Hence, health centers must spend valuable time and resources "selling" the merits of their projects to multiple CDEs, any one of which has a limited supply of tax credits to offer. The result is that sometimes a health center must convince two or more CDEs to invest in its project, since each CDE is limited in the amount it can make available to eligible borrowers. While an extremely valuable program, its complicated processes and eligibility requirements continue to create hurdles for health centers.

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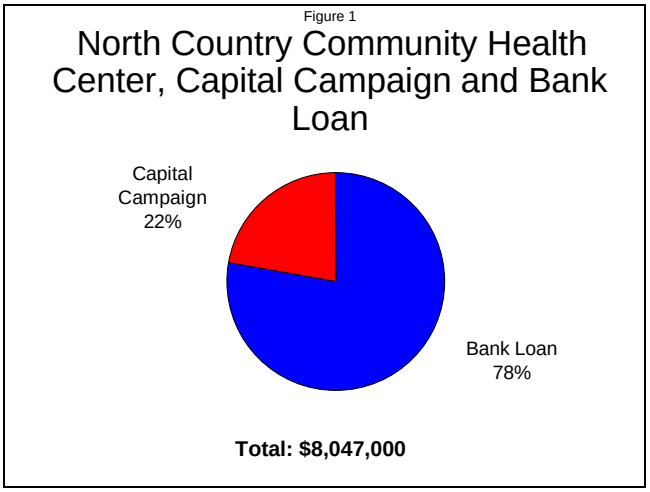
[1] P.L. 95-83.
[2] P.L.104-299.
[3] Health Resources and Services Administration. "Loan Guarantee Program for Health Center Facility Projects." Program Information Notice #97-20. http://bphc.hrsa.gov/policy/pin9720.htm.
[4] Health Resources and Services Administration. "Hill-Burton Free and Reduced Cost Health Care." http://www.hrsa.gov/hillburton/default.htm.
[5] Congressional Research Service. "The Hill-Burton Uncompensated Services Program." Report for Congress. May 23, 2005.
[6] Health Resources and Service Administration. "Hill-Burton Facilities Obligated to Provide Free or Reduced-Cost Health Care." http://www.hrsa.gov/hillburton/hillburtonfacilities.htm.
[7] Based on communication with officials at the Health Resources and Services Administration, HRSA.
[8] U.S. Department of Agriculture. "Rural Development Housing & Community Facilities Programs." http://www.rurdev.usda.gov/rhs/cf/cp.htm.
[9] U.S. Department of Agriculture. "Community Facilities Guaranteed Loan Program Lender's Handbook." http://www.rurdev.usda.gov/rhs/cf/CFG/CF%20Lenders%20Handbook.pdf.

Appendix B
Funding Sources for Health Center Capital Projects: Examples

The following examples illustrate how health centers have used many of the funding sources described in Appendix A to fund their capital projects.

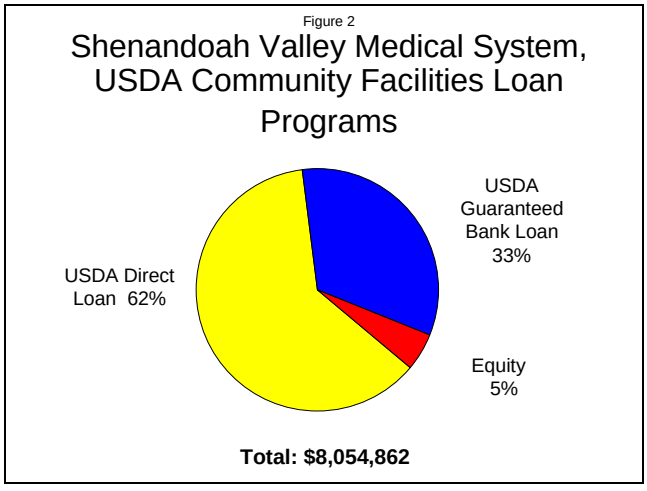
Capital Campaigns and Bank Loans. Many health centers finance capital projects using the traditional formula of a sizable down payment of capital generated from a fundraising campaign combined with a commercial bank loan. North Country Community Health Center in Flagstaff, Arizona recently completed an $8,047,000 facility financed using this method. Unfortunately, most health centers take years to raise the capital funds this type of financing requires. They also may face relatively high interest rates from commercial lenders.

Figure 1



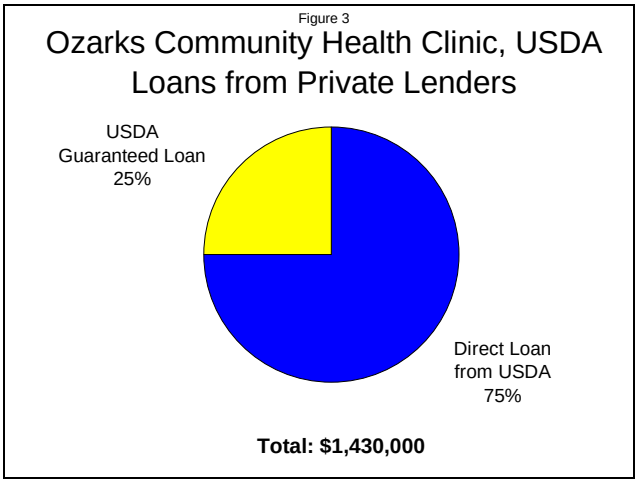
USDA Community Facilities Loan Programs. In 2003, Shenandoah Valley Medical System in Martinsburg, West Virginia raised $8,054,862 to build a 47,440 square foot facility to consolidate the operations of five existing sites and expand capacity. The majority of the project was financed by a direct loan from USDA and a USDA-guaranteed loan from a commercial bank.

Figure 2



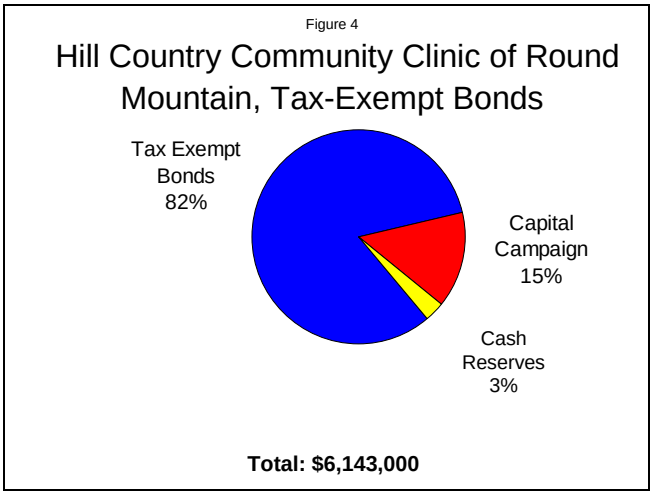
In some cases, rural health centers lack any capital to contribute to their projects. To overcome these challenges, many rely on USDA grants, loans, and loan guarantees. Ozarks Community Health Clinic of Ava, Missouri financed a $1,430,000 million, 15,000 square foot facility using only a USDA direct loan and a USDA guaranteed loan from a private lender.

Figure 3



Tax-Exempt Bonds. Some health centers have been successful using tax-exempt bonds to finance an upgrade of their facilities. Although the tax-exempt status of these bonds reduces long-term interest rates, they often include higher upfront costs. Also, because of the patchwork of bond issuers, identifying local issuers and completing the financing arrangements can cause significant delays. Hill Country Community Clinic of Round Mountain, California utilized this approach along with a capital campaign to augment their cash reserves for construction.

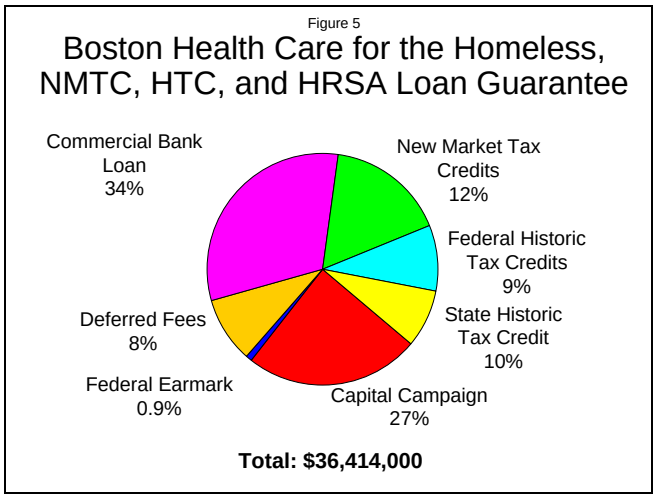
Figure 4



Tax Credits. Because health centers are frequently located in high need areas, they are strong candidates for New Markets Tax Credit financing and in some cases Historic Tax Credits

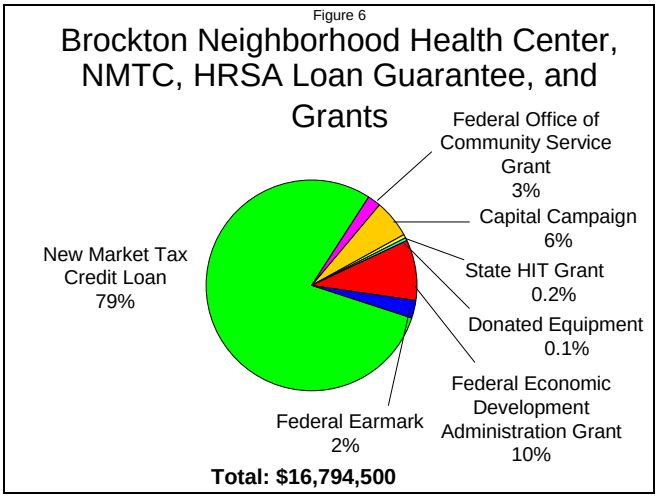
as well. By using various types of tax credits, health centers have successfully added considerable equity to their projects, helping to reduce their long-term debt burden. Finally, health centers have learned to further enhance their transactions by combining tax credits with the HRSA loan guarantee program. Using this combination, health centers have been able to increase both the amount of equity available to the project *and* achieve a lower interest rate for the debt portion of their financing. This is the approach that Boston Health Care for the Homeless in Boston, Massachusetts took.

Figure 5



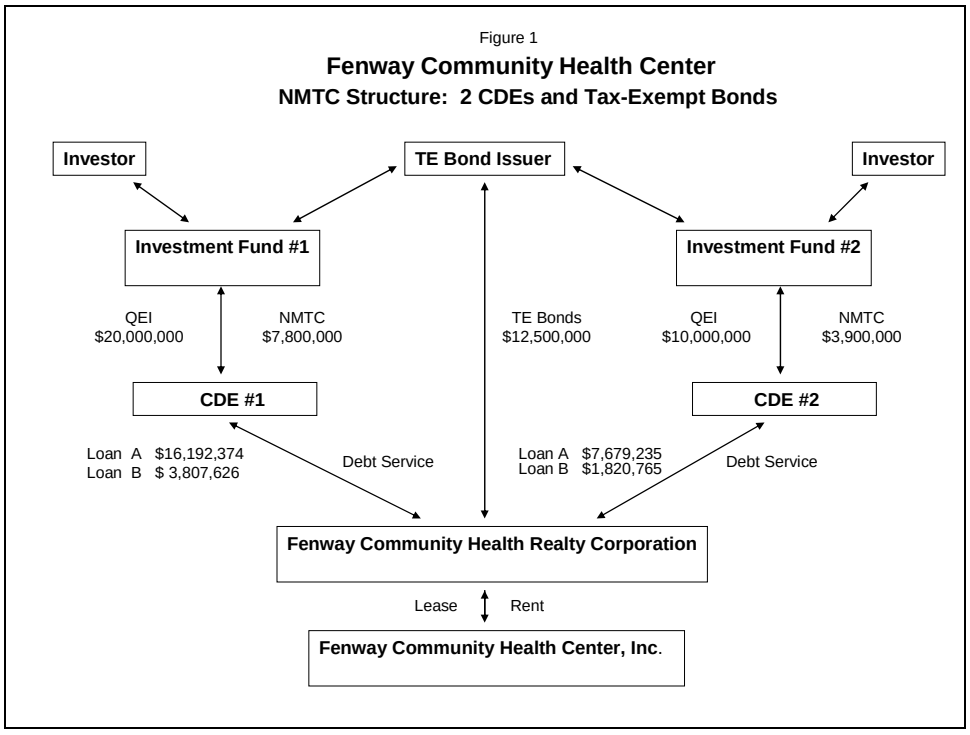
In another example, Brockton Neighborhood Health Center in Brockton, Massachusetts was able to finance a $16,794,500 project using New Markets Tax Credits combined with a variety of other federal, state, local, and private resources, including the HRSA Loan Guarantee Program, to complete their project.

Figure 6



Appendix C
How the New Financing Paradigm Works:
The Case of Boston's Fenway Community Health Center

One health center so far has proven that it can be done. The center managed to assemble both tax-exempt bonds and New Markets Tax Credits for its project, but doing so was an enormously costly endeavor in terms of time, complexity, and upfront fees. In 2007, Fenway Community Health Center in Boston, Massachusetts succeeded in marrying the requirements of these two financing mechanisms into an effective financing structure that allowed the health center to carry out a capital project that would have otherwise been unaffordable. The $55.5 million project was funded with a $7.5 million capital campaign, the sale of an existing building, and $44 million generated from a $36.4 million tax-exempt bond issuance and $5.6 million in "near equity" from New Markets Tax Credit investors. The transaction required the participation of two different Community Development Entities (CDEs) with tax credit allocations, a tax-exempt bond issuer, and a letter-of-credit bank to provide credit enhancement for the bonds. As demonstrated below, a diagram of this transaction only begins to represent the complexity involved in assembling the capital for this project.



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