

Chapter 3C

Access to Capital for Critical Access Hospitals

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Introduction

Policymakers and rural advocates have expressed a growing concern about the ability of small rural hospitals to obtain capital to improve and modernize operations (National Advisory Committee on Rural Health, 2000). The fear is that a lack of access to capital coupled with the ongoing financial demands on small rural hospitals will precipitate a variety of problems for rural communities (e.g., loss of access to needed health care services, erosion of local economies and increased demands on regional resources to fill the gap). While the degree and scope of the potential risk involved for rural communities can be debated, health care continues to be a capital-intensive enterprise as consumers and practitioners insist on the latest technologies and amenities from aging facilities. A variety of factors complicate the process of obtaining access to capital, including limited service area populations, depressed local economies, and a small pool of medical professionals who are often difficult to recruit and retain (National Advisory Committee on Rural Health, 2000, Standard & Poors, 2000).

Traditional sources of funding are not as reliable as they once were for meeting capital needs (e.g., internal operations, bridge loans, charitable donations, tax levies and public fund-raising efforts). Fundraising efforts, while highly visible and occasionally significant, usually only cover a minor portion of the needed capitalization. Taxation authority provides a degree of financial flexibility and relief but differs from state to state. Since it ultimately relies on the financial health of the local community, it is not a sufficient source of support to fully underwrite hospital capital projects. Even bond sales, still the most popular source of debt financing, have become more difficult to obtain over the last several years for all but those hospitals with the highest credit rating. Tapping into hospital reserves or drawing down on unrestricted or dedicated funds may seem to be reasonable approaches. However, they can further weaken the chances of some hospitals to obtain loans because they undermine what might have been a stronger balance sheet (e.g., through increased leverage and declines in days cash). This is especially true for hospitals in volatile markets where lenders become very concerned about the availability of borrower reserves to serve as buffers against unforeseen market developments.¹ These issues take on a special importance for small rural hospitals because their projects most

¹ Private lenders and private mortgage insurance brokers have remained absent in New York State for years because of the fear that operating in a rate-setting “all payer” state made even financially healthy hospital operating environment too risky (i.e., state changes in payment regulations could undermine a borrower’s ability to repay obligations without warning).

often involve efforts to replace or renovate infrastructure, with little potential for creating new revenue that can be dedicated to repaying the new debt.

Hospital capital loans are leveraged by loan servicers through the sale of bonds to investors. The loan servicer (either private or public entity/agency) is responsible for collecting, monitoring and reporting loan payments, in this case hospital mortgage payments, that are then used to compensate bondholders in accordance with the terms of the sale. In cases where a hospital's balance sheet is considered weak, it is still possible to obtain a loan if the facility can secure a mortgage insurance endorsement.² According to the Health Care Financing Study Group,³ about sixty percent of all (urban and rural) hospitals seeking financing in the mid-1990's could not secure a loan based solely on their own financial strength. While the majority was successful in obtaining a capital loan following mortgage insurance endorsement, just under a fifth were still considered too risky by private mortgage insurers.

Federal Capital Assistance Programs

Two major federal programs represent lenders of last resort for small rural hospitals unable to borrow from private markets. The U.S. Department of Housing and Urban Development (HUD) and the U.S. Department of Agriculture (USDA) have each made capital available to rural hospitals for the past thirty years through special programs. However, even with their long tenure in capital markets, the relative impact on rural hospital capital needs has been negligible, suggesting that a number of rural hospitals may be permanently blocked from garnering sufficient capital to continue modern operations.

Recent analyses of the program portfolios of these two initiatives (Gregg, Knott & Moscovice, 2001) have revealed that only a quarter of the more than 2,000 rural hospitals in operation today have taken advantage of either program. Eight out of ten endorsements under the HUD 242 Hospital Mortgage Insurance Program were made to non-rural hospitals that received an even larger proportion of committed funds. Support under the USDA Community Facilities Program specifically targets rural capital needs and provides grants, direct loans and mortgage insurance endorsements for a wide range of projects.

Hospital Mortgage Insurance Program (HUD 242)

Over its 33-year history, the HUD 242 Program has made billions of dollars available for hospital projects that otherwise may not have been completed. However, urban hospital projects have accounted for approximately 84 percent of all endorsements and 97 percent of all funding.

² Mortgage insurance, as available through the HUD 242 Program or other private market entities, insures the lender (not the borrower) against financial losses if the borrower defaults on obligations.

³ The Health Care Financing Study Group is comprised of investment and mortgage banking firms actively involved in financing health care facilities throughout the United States, both conventionally and on a government-supported basis.

Recently, personnel from the Federal Housing Administration (FHA), the agency directly responsible for administering the HUD 242 Program, have developed a specific mortgage insurance process that recognizes the special circumstances of critical access hospitals (CAHs). The process is based on the same standards of the full HUD 242 Program but uses the CAH reimbursement methodology in eligibility calculations. The use of cost-based reimbursement assumptions for determining eligibility can make a number of CAHs eligible for mortgage insurance that otherwise would not have qualified.

HUD and HHS officials have undertaken this effort because of increased concern about small hospital capital needs and a growing awareness of the many market pressures facing rural hospitals. Unfortunately, this program can offer little help beyond what is already available from private markets because of the fiduciary responsibilities imposed by Congress (i.e., remain self-supporting and avoid significant risks of default). The FHA has been very successful in meeting this charge and has maintained a default rate of less than three percent since the program's inception, a rate that is comparable with corporate bond markets (over 2%) and a little more than municipal bond markets (around 1%) (BMA, 1995).

USDA Community Facilities Program (CFP)

Unlike the HUD 242 Program, the CFP specifically targets rural capital needs. However, it is not limited to assisting hospitals or even health care providers. Even so, loans under this program for rural hospital-related projects have comprised a significant portion of its portfolio. Over the lifetime of the program, close to a quarter of its total funds—approximately \$1.2 billion—have been obligated for rural hospital projects. Since its inception in 1974, the CFP has made 817 loans, loan guarantees and grants to 734 distinct rural hospital projects. Direct loans have totaled \$4.4 billion, with an average of \$458,602, while guaranteed loans and grants have totaled \$706.9 and \$47.9 million respectively, with average amounts of \$990,038 and \$33,573.

Program funding decisions are made by individual USDA state offices out of a state pool allocated according to such factors as rural population size, unemployment, and the number of households below the poverty level. Each state receives a minimum allocation. USDA state offices score the applications and make decisions on all loan projects under \$3 million. Loan projects over \$3 million involving entities with an operating history shorter than five years require the approval of the program administrator.

Results from Surveys of CAH Administrators

Program Awareness of CAH Administrators

The 2000 and the 2001 CAH administrator surveys were designed to identify measures of change in financial health and adaptability following conversion to CAH. Specific questions were asked about obtaining capital loans, the projects involved, knowledge about existing federal programs

providing capital, and indicators of changes in financial flexibility (i.e., the ability to draw upon multiple sources of capital to buffer against financial pressures).

Three-fifths of the administrators were not familiar with either the HUD 242 Hospital Mortgage Insurance Program or the USDA's Community Facilities Program. In addition, only one-fourth of the hospitals surveyed were aware of the special CAH related process that had been developed for the HUD 242 Program (Table 1). These findings are not surprising considering the histories of the programs.

Until recently, the HUD 242 Program was not marketed aggressively beyond the eastern seaboard (over 80% of the 242 portfolio endorsements are for hospitals in New York State – mostly from New York City). Although the modifications in the eligibility criteria for the HUD 242 Program regarding CAHs promise to assist many facilities, the program was launched only recently and has been marketed largely on a request basis. The CFP has been active in all states with rural areas. However, largely because of the varied target populations, and ongoing difficulties with fully staffing field offices, it is not surprising that rural hospitals may have an incomplete understanding about the program and what it may have to offer in terms of their capital needs.

The existence of information gaps or uncertainty about the purpose and mechanisms of these programs could be interfering with the ability of a number of hospitals to access needed capital resources. Much needs to be done to fill the gap and educate CAH administrators and board members about these programs and their potential for meeting capital needs. In lieu of aggressive ad campaigns by HUD in other states or the costly expansion of USDA field staff, new strategies need to be explored. As in other phases of the Flex Program, a stronger presence of a state office of rural health and State Healthcare Association partnership could improve the ability of eligible rural hospitals to obtain the capital they need.

TABLE 1

CAH ADMINISTRATOR FAMILIARITY WITH FEDERAL CAPITAL PROGRAMS, 2001

	Percent Familiar
HUD 242 Hospital Mortgage Insurance Program	43%
HUD 242 Hospital Mortgage Insurance for CAHs	24%
USDA Community Facilities Program	41%

Efforts to Obtain Capital Resources

Thirty-seven percent of CAHs surveyed in 2001 obtained some form of capital loan to maintain code compliance, renovate, and modernize or replace needed equipment. One out of five initial borrowers were able to secure a second loan, making a total for capital loans of \$261.2 million. The average loan amount for initial loans was \$1.7 million, with a median of \$400,000, and the average size for second loan was \$676,000, with a median of \$100,000. More than half of the initial loans and almost two-thirds of the secondary loans were underwritten by local lenders.

Even though a larger proportion of loans than expected were underwritten by local lenders, the overall pattern of loans (i.e., proportion of loan dollars and loan endorsements) underscores some of the general issues involving capital markets available to rural hospitals (see Table 2). Private sources of capital accounted for the majority of dollars committed for both initial and secondary loans (62% and 61% respectively) while local lenders accounted for the majority of loan endorsements (58% and 64% respectively). In general, loans from local lenders and from private sources were significantly less for a second loan (i.e., 7% of initial loan for local and 3% for private lenders). While on average secondary federal loans were only slightly less than initial loans, this was probably influenced by the fact that 60 percent of the secondary loans appeared to be roll-up or refinancing loans (i.e., significantly larger than the initial loan).

TABLE 2

**LOAN AMOUNTS AND NUMBER OF LOAN ENDORSEMENTS
BY SOURCE OF CAPITAL FUNDING, 2001
(N=124)**

SOURCE	AVERAGE LOAN	PERCENT OF LOANS	PERCENT OF DOLLARS LENT
Local Lender	\$ 560,000	58.0%	18.4%
State Programs	\$1,860,000	11.3%	11.9%
Federal Programs	\$1,240,000	11.3%	7.9%
Private Sources	\$5,630,000	19.3%	61.8%

The loans were used for a wide variety of purposes ranging from meeting financial needs (i.e., “cash flow issues”, “covering operating expenses” and “paying back Medicare”) to major building projects involving millions of dollars. Major building projects ranged from building new hospital facilities with prices as high as \$20 million to the expansion of clinical facilities. The next most expensive loan project category involved purchasing major non-movable medical

equipment such as CT scanners or X-ray machines, and replacing big-ticket physical plant items such as boilers and electrical generators. Among the smallest loans were those used to update and modernize telecommunications capacity, such as installing a new billing information system, replacing out-dated computer equipment and installing new phone systems.

It was not possible to examine facility-specific cost report information, so the relative financial strengths and needs of these hospitals are not available at this time. However, it is likely that those hospitals that received the largest loans from local lenders were the strongest financially. Information obtained through the CAH survey identified a low refusal rate (11%) of relatively small loan amounts (i.e., \$100,000 or less). Prior research on capital access issues (Gregg, Knott & Moscovice, 2001) revealed that the chance of obtaining a loan, especially from non-local private markets, becomes more problematic with loan requests that are less than \$400,000. Although this limitation could also affect hospitals that obtained federal hospital mortgage insurance, information from the CAH survey suggests that program participation may positively influence a hospital's ability to obtain loans traditionally under the floor (\$400,000) considered acceptable by most private market lenders and loan servicers.

Financial Flexibility and CAH Conversion

Financial strength depends on a healthy bottom line and cost-based reimbursement can help. The more a hospital can obtain some relief from the interest rates on existing debt or greater flexibility through a line-of-credit with vendors to manage cash shortfall periods, the better it will be able to remain fiscally viable.

A number of site visits as well as discussions with small rural hospital administrators have revealed that many think the image of their facility in the local community can directly influence revenue/cash flows in their hospitals. Perceptions and attributions about a facility by consumers and other providers can influence patient referral, utilization and revenue flow as well as the nature of financial transactions. For example, attributions about performance, future prospects and continued operations can influence banks, vendors and creditors to give or not give the hospital the benefit of the doubt. Without an operational turnaround under the Flex Program and a greater expectation of an improved bottom line, a number of CAH administrators have commented that they probably would not have been considered a good candidate for a loan. To explore these impressions, we included a number of specific questions in the 2001 survey to identify direct experiences in obtaining a better bargaining position or greater financial flexibility to manage the necessary transactions to operate the hospital. Findings suggest that in many cases conversion to CAH can have a direct influence on financial flexibility (see Table 3).

TABLE 3**OPPORTUNITY FOR GREATER FINANCIAL FLEXIBILITY UNDER CAH, 2001**

	Percent Reporting Direct Experience
Funding Capital Depreciation	50%
Obtaining Forbearance or Line of Credit	32%
Obtaining a Capital Loan or Issuing Bonds	27%
Obtaining a Lower Interest Rate on Existing Debt	25%
Obtaining or Maintaining a Local Tax Subsidy	23%

Conclusion

The Flex Program is relatively young compared to the long-term obligations required for major capital loans (i.e., 90% of the hospitals have been operating as CAHs for less than three years). Operating histories will likely need to lengthen before capital markets begin opening up to CAHs. The flexibility incorporated into the HUD 242 Hospital Mortgage Insurance Program reflects a level of understanding and confidence that only seems present in federal programs. It will take some time for a similar level of comfort to accrue for private capital market decision makers. The availability of funds through local lenders is problematic as the current downturn in local economies continues. State programs are likely to be further reduced as more states report budget losses and shrinking general fund pools.

Improving access to capital resources for small rural hospitals will remain problematic regardless of the availability of capital for making investments (i.e., making more money available is a necessary but not sufficient strategy). Unless some headway is made in removing the real/perceived uncertainty of future operations of small rural hospitals, lenders will remain cautious and reluctant to accept the risk of endorsement. Participation in the Flex Program offers a way to overcome this uncertainty and a vehicle for eventually obtaining access to capital from private markets. This access can be accomplished by mortgage insurance in the short run and in the long run from markets as the confidence in the longevity and the operational strengths of CAHs continues to grow.

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