

Financial Trends Research and Capital Strategy Initiative: Developing Resources for Health Centers in Pennsylvania



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Can We Agree?

On a Common Goal

“Meet the long-term primary health care needs of Pennsylvania’s low-income residents”

On This Premise

“All health centers working together have more power and influence than any one on its own”

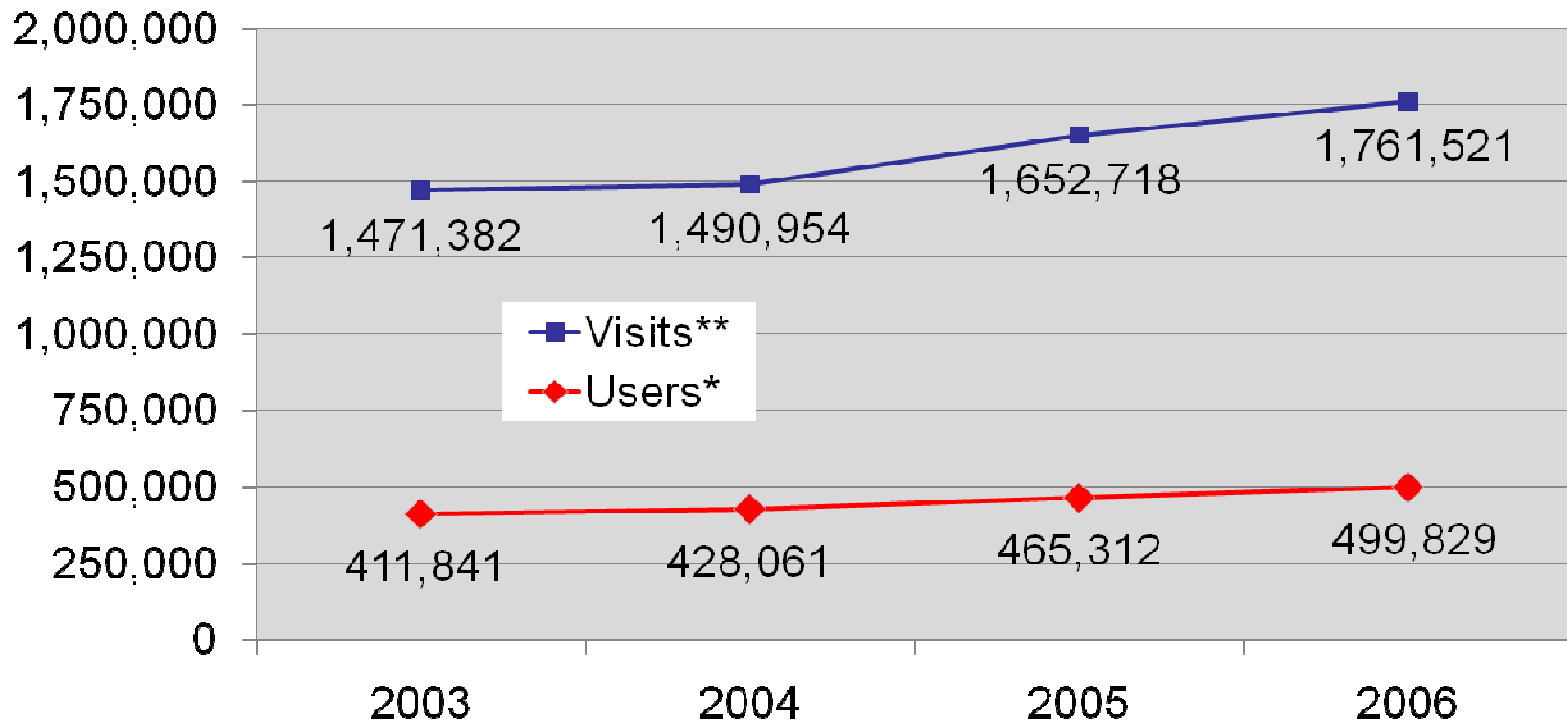
Who are we now?

Pennsylvania Community Health Centers – Current Statistics

- 32 community health centers providing care through 174 sites
- Over 499,829 individuals served (2006) - 7th highest in US in numbers
- 128,479 uninsured (25.7%) - 13th highest in US in numbers
 - 203,759 Medicaid (40.8%) - 13th highest %, 6th highest in numbers
 - 167,591 Medicare, Private or other Public Insurance (33.5%)
- 331,456 are below 200% of poverty (66.3%) (27.9% Unknown)
- 2,613 FTEs - 9th highest in US in numbers

PA Health Center Patients and Visits 2003-2006

PA Health Centers





Can You Meet Current and Future Demand?

- Will you need to grow your capacity?
- If yes, can you afford to do so at a pace to meet the demand for primary health care services on your own (with your current resources)?
- If no, what do you need to accomplish this goal? (access to planning assistance and sources of low- and/or no-cost capital).



How do you get the Resources?

- Who can you go to for help? (who shares your goal and who benefits from your success – the state, health insurers, hospital systems, foundations)
- What do you ask them for? (grant pool, access to bond financing, low interest loans, other?)
- How do you make the case to them?
 - demonstrate the need,
 - propose a solution that shares the burden,
 - identify and describe the ultimate benefits to you – AND TO THEM!)



PA Forum and Capital Link Partnership

- PA Forum and Capital Link will be working together over next few months to develop strategy to access additional resources
- Will require involvement and information from the health centers



What Makes Financing CHC Capital Projects so Difficult?

Lack of Equity:

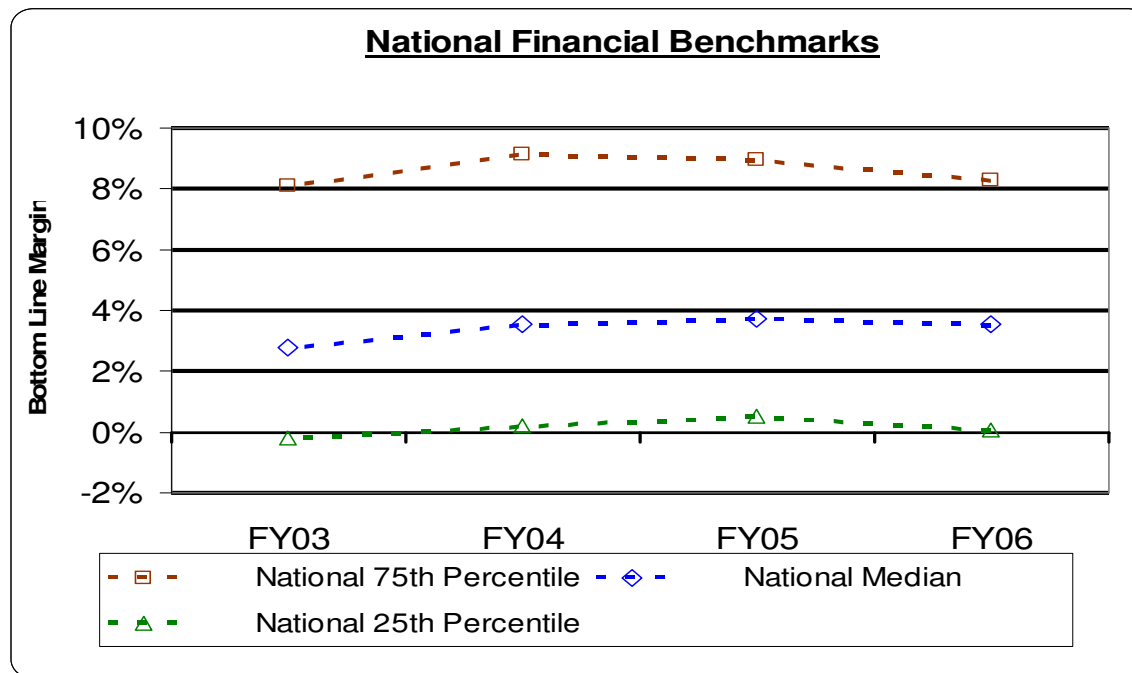
- Limited experience and/or success with fundraising
- Lack of cash reserves
- No endowments

Limited Debt Capacity:

- Slim profit margins or losses
- Low cash reserves
- Little experience with debt financing
- Hard for lenders to understand & assess risks
- High percentage of government payors

Perception vs. Reality:

Some CHCs are relatively strong



	FY03	FY04	FY05	FY06
Sample Size	441	388	280	117
National 75th Percentile	8.12%	9.15%	8.95%	8.28%
National Median	2.80%	3.55%	3.74%	3.57%
National 25th Percentile	-0.21%	0.19%	0.54%	0.09%



Which Health Centers Will Be Able to Expand Successfully?

- CHCs that demonstrate sufficient organizational capacity to stimulate investments from grantors and lenders
 - Management & Board strength
 - Good internal planning capacity
 - A compelling business case
 - Leveraging community partners / resources
 - “Staying power”

How Will Health Centers Meet Their Capital Needs?

- Health Centers generally need both debt and equity to fund capital projects.
- Capital Link's completed projects show on average a 60% Debt / 40% Equity mix.
- But philanthropic funds are always in short supply
- Lowering the cost of debt reduces the grant funding amount – and decreases the amount of time needed to complete your capital project.
- Leveraged New Markets Tax Credit transactions do the same – by increasing the net equity

Leveraging Capital Resources

Where will the \$ come from?!

- A. Federal grants and loans
- B. State grants and loans (CDGB)
- C. Private grants and loans
- D. Individual donations (Capital Campaign)
- E. Credit enhancement sources (HRSA, USDA)
- F. Tax credits
- G. All of the above!



Key Capital Funding Source:

- **New Markets Tax Credits**

- \$15 billion program established in late 2000
- Provides tax-credits to investors that provide capital to for-profit Community Development Entities – they in turn lend to CHC's
- CDEs must invest in/lend to for-profit and nonprofit businesses that are located in and serve low-income communities
- Tax credits will equal 39% over 7 years (5% in first 3 years, 6% for next 4 years)
- Represents the largest new federal investment in community-based development in 15 years
- **Can be used in conjunction with BPHC Loan Guarantee Program to provide low-cost loans**



NMTC Advantages

- Source of up to 25% of project costs (equity)
- Attracts and leverages private sector investor dollars
- Can leverage Foundation grants and capitalized costs (money already spent in the project)
- Doesn't ask for a pure handout – “we'll do what you can, we even bring in new private sources of capital and the state fills the gap”



NMTC Challenges

- Credits are limited – one more round of allocations to be made (though program could be extended) – applications due in Feb.
- Census track-based – all potential sites need to qualify (though new targeted Population regs. could help)
- Program is complicated – grants become loans for 7 years – and that concept is **GUARANTEED** to confuse bureaucrats



Examples from Other States

It's been done before!

- Washington DC
- Missouri
- Indiana
- Louisiana



Medical Homes DC: *Background*

- Poor health outcomes despite large amounts of dollars spent on health care in District of Columbia
- Critical shortages of physicians in neighborhoods with high concentrations of poverty
- High levels of avoidable hospital admissions
- Historically, city's primary care model has been the free-clinic – challenge in converting to FQHC model



“Medical Homes DC” Solution

- \$145 million investment in primary care to provide low-income people with better access to health care services in their communities
 - Implemented over ten years
 - Clinics to serve 210,000 medically vulnerable residents
 - For buildings, capacity and quality



Missouri Experience - *Background*

Initial Concept:

- MO would award \$60 million in grant funding to the Missouri Primary Care Association (MPCA) to be leveraged by an additional \$33 million in funds from other sources - NMTC and USDA - to develop a \$93 million pool of capital resources for MO FQHCs.
- MPCA contracts with Capital Link to assist with the development and ongoing management of the Program.



Missouri Program Status

- Effort started in 2003-4
- **PCA contracts with CL for CNS/FTA/SEIA** – identifies HC needs in order to support a request for a state capital grant pool
- PCA uses data in fall of 2005 to respond to outreach by Governor's office to offset cuts to Medicaid eligibility in August 2005 - PCA made Governor aware of impact on CHCs (**Governor had political problem!**)
- Initial 2006 funding based on sale of assets of MO Health and Education Loan Authority (MOHELA privatization)
- To be used for facilities statewide including \$60M for HCs, but legislation falls through because legislature decides it does not want to privatize MOHELA!
- PCA decides to try again and **asks CL for update of CNS/FTA** - \$93 million capital need identified
- PCA asks CL to help put together proposal to Governor's office in fall of 2006 for same \$60 million with NMTC leverage to fill gap



Missouri Program Status

- PCA and CL sit with Governor's office and budget office in spring 2007 – all seems well but then suddenly \$ not available for Program Development (usually 3-4%) or to use through NMTCs.
- Now \$60 million goes directly to the health centers, administered by the PCA, based on the amounts submitted in the original Capital Needs Survey. PCA reimbursed for its basic program administration costs.



Indiana Experience

- State has long history of supporting CHCs with operating money - \$30 Million/yr.
- PCA stressed capital need in addition to operating need.
- In 2006 PCA used CL's CNS to determine the capital needs of HCs
- Result is additional \$30 million (\$60 million) added in 2007 to be spent over 2 years for operations and capital.



Indiana Program Development

- PCA has always encouraged HCs to educate their representatives – most have good standing relationships already in place – they even encourage patients to communicate with reps. PCA also has great relationship with Chair of Ways and Means – so by-passed some of the political issues (**recruit powerful champions!**)
- PCA also works with advocate (lobbyist) to work with related agencies (rural health, hospitals) so they are not at cross purposes or competing (**encourage all collaborations - one good turn deserves another!**) BUT, PCA advised HCs to keep low profile on capital issue – don't draw attention to it to avoid conflict with other advocates of worthy causes
- PCA involved with DoH to structure program but did not try hard to get the money themselves (read political winds and had great relationship with new head of CHC relations at DoH)

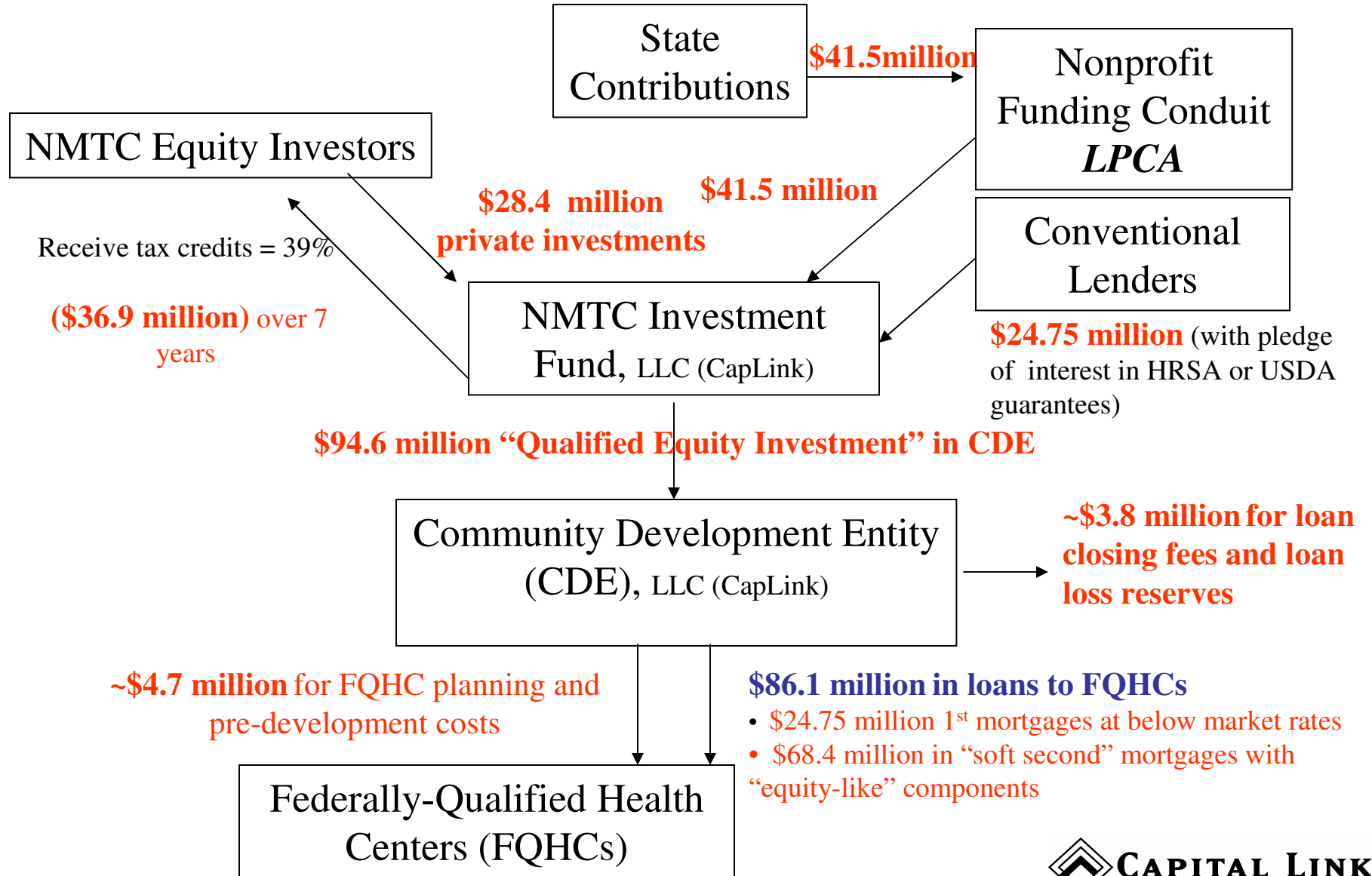


Louisiana Experience

- In aftermath of Hurricane Katrina, State is examining ways to restructure its health care system
- Growing consensus on need to fix Charity Hospital system and expand access to primary care
- Louisiana Primary Care Association has been aggressive in its advocacy for expansion of FQHCs
 - Asks for \$55 million based on CL Capital Needs Survey leveraged by NMTC - as noted on following slide

ACT 203

Louisiana Capital Development Fund for Community Primary Care Clinics (FQHCs)





Louisiana Program Status

- Katrina offers opportunity for health care system redesign – PCA makes the case to Governor that HC model works (Medical Home) – CNS/FTA shows \$124M in total capital need
- Governor agrees to include \$55 million - included in the Governor's original budget for health center expansion – but in a budget reduction effort, it is subsequently moved from Gov's to Legislative budget (usually the kiss of death)
- CHCs, LPCA and key champions (including legislators) conduct intense advocacy effort – rescue it and legislature votes to expand cap and use recovery money for non-recurring projects
- LPCA/CHCs acknowledge competing interests and do not fight \$14 million carve-out for Rural Health Coalition & others



Louisiana Program Status

- Net result is \$41.5 million for CHC capital projects.
- Grant \$41.5\$ to LPCA for distribution and provide specific legislative 'encouragement' to use grant funds within New Markets structure.
- LPCA and LA DHH signed Cooperative Agreement in January, 2008.
- Clinics expected to demonstrate expanded capacity (additional users).



Capital Development Programs: What do they have in common?

- Vision
- Commitment and Leadership
- Focus not just on \$, but also on technical assistance so that health centers and clinics can effectively make use of the \$ available and use the opportunities for strategic advantage



Capital Development Programs: How do they differ?

- Each state has different opportunities
 - Political
 - Financial
- Each state has different needs
 - Financial and operational strength of the health centers and clinics as a group affects the strategy for developing a capital program
- Philosophical Differences
 - Grants vs. Loans



Strategies for Developing State-Based Grant & Loan Programs

- Identify models developed in other states and build upon them (**don't reinvent the wheel where you don't have to!**)
- Target existing resources to develop CHC-specific programs
- Work to develop new CHC-specific programs with partners and allies - but be ready to compromise and share with allies (and competitors) to get what you want!
- Understand the bureaucratic realities



Lessons Learned in Developing State-Based Grant & Loan Programs

- Some legislative pushback is possible as a result of other agendas
- The issue can become a political football – and maybe not due to CHCs (be careful what you tie your horse to!)
- Is there any precedent in the State for granting big \$ to a non-state agency for re-distribution? If not, expect lots of new parties to ask for a piece
- Figure out the distribution model early – don't just focus on getting the pool created. Get state acquainted with partners early
- HCs need to understand implications – “if you don't ask, you won't get” – don't be outrageous but don't under-estimate
- HCs need to be ready and comfortable doing grass roots advocacy



OK, So How Do We Get Started?

Make a compelling case of the need:

- **An accurate assessment of required capacity**
Capital Link's Capital Needs Survey
- **An accurate assessment of financial self-sufficiency**
Capital Link's Financial Trends Analyses creates Financial Information Database and estimates Debt Service Capacity
- **A compelling case for all audiences:**
We will:
 - Create new Community Health Care Resources
 - Leverage state money with private resources
 - Save overall health care dollars through primary care or medical home model
 - Create Economic Engines in low-income communities



Capital Link's Data Analysis Tools

◆ **Capital Needs Surveys and Financial Trends Analysis**

- ◆ Uses information from questionnaire and audited financial statements
- ◆ Assesses overall capital needs of health centers on a statewide basis
- ◆ Evaluates what health centers can afford to do on their own
- ◆ Results used to inform development of capital resources that respond to identified needs



Capital Link's Data Analysis Tools

◆ **Economic Impact Analysis**

Macro-economic modeling to demonstrate the role of a community health center as a springboard for economic development within the community.

Health Centers from an Economic Development Perspective

- ⌘ Enhanced health care services
- ⌘ Referrals to larger health providers
- ⌘ A place for employment training
- ⌘ Community-based employment
- ⌘ Infusion of spending into the community
- ⌘ Anchor for attracting new businesses and investments into the community
- ⌘ Product of a community effort



What we will need from the health centers

- Last three years of audited financial statements
- Responses to Capital Needs Survey
- UDS reports for the last three years (if data not available through PA Forum)



Capital Link's Data Analysis Tools

Importance of Confidentiality

- ◆ CL will not disclose health center-specific financial data to any party other than the health center itself, unless the health center requests such further distribution in writing.
- ◆ Any reports will include only aggregate data for a group of health centers as a whole.



Capital Link Background

- **Mission:** Capital Link is a national nonprofit organization
 - We assist health centers in planning and obtaining financing for building and equipment projects, and
 - We assist Primary Care Associations (PCAs) and other partners in leveraging capital resources for health centers on a statewide, regional and/or national basis
- **Founded** as a joint effort of NACHC, the Community Health Center Capital Fund, and Primary Care Associations in MA, IL, NC, and TX
- **Staffed** in nine offices (MA, CA, DC, LA, MD, MO, NC, WA, WV)
- **Receives funding** through contracts with HRSA and through fee-based contracts to assist health centers and PCAs nationally



Capital Link Track Record

- Established award-winning tax-exempt bond financing program in MA (1994)
- **Funding Assistance:** assisted health centers in obtaining almost **\$342** million for **146** projects totaling **\$466** million:
 - **\$143.7** million in bank or other loans (including conventional lenders, USDA, CDFIs, HUD, NMTC/HTC) for **54** health centers **(66 transactions)**
 - **\$119** million in tax-exempt bond financings for **17** health centers **(23 transactions)**
 - **\$57.8** million in grants/equity for **58** health centers **(67 transactions)**
 - **\$14.4** million in forgivable loans for 6 health centers
 - **\$3.1** million in equipment loans for **5** health centers **(6 transactions)**
 - **\$3.4** million in lines of credit for 7 health centers



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