



Capital Plans and Needs of Health Centers

A National Perspective

Prepared by Capital Link | Summer 2014

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Capital Link, established in 1998, is a non-profit organization that has worked with hundreds of health centers and primary care associations for over 15 years to plan capital projects, finance growth, and identify ways to improve performance. From market feasibility and program, staff, and facility plans to comprehensive financing assistance, Capital Link provides innovative consulting services and extensive technical assistance with the goal of supporting and expanding community-based health care. Additionally, Capital Link works in partnership with primary care associations, the National Association of Community Health Centers, and other entities interested in improving access to capital for health centers. For more information, visit www.caplink.org.

Introduction

The dramatic increase in community health center patients over the past several years has necessitated rapid growth in health center facilities. Between 2005 and 2012, patients of Section 330 health centers¹ grew 50% from 14.1 to 21.1 million requiring a \$12.5 billion increase in health center property, plant, equipment, and leased space to accommodate the nearly 25,000 providers who serve them. Continued expeditious investment in fixed assets (both owned and leased) will be necessary to enable health centers to grow to serve the 35 million patients expected as a result of the Affordable Care Act's (ACA) implementation.

Capital Link conducted a national capital needs assessment of community health centers in the fall of 2013 to determine their capital project plans, investment needs, sources of capital, projected funding gaps, and growth readiness to expand facilities to meet the projected overall market need. The research indicates planned capital projects would provide capacity to serve 30 million patients annually by 2018, but considerable uncertainty exists regarding whether the necessary funding and other needed assistance will be available to support the desired growth. Furthermore, this level of facility investment will not be sufficient to accommodate the number of patients projected to be served by health centers between FY16-18. Key findings and implications from the assessment are described below.

Community Health Center Capital Project Plans and Funding Needs 2014-2018

Health center capital needs data was solicited from the approximately 1,200 Federally Qualified Health Centers (FQHCs)² nationally and collected from 398 health centers in all 50 states, DC, and Puerto Rico, representing a response rate of 33%.

Three-fourths of the responding health centers reported plans to initiate one or more projects over the next five years to replace, renovate, or improve current facilities and/or to expand existing capacity. The projected cost of the capital development is \$1.7 billion. Extrapolating that figure to the national universe of 1,200 health centers, Capital Link estimates planned capital investments for all health centers of \$5.1 billion over the next five years for owned facilities and \$2.6 billion for leased space.

The facilities investment, if implemented and funded, would allow health centers to accommodate an additional 5.9 million patients for a total capacity of 30 million patients and 31,000 providers in 2018. With 32 million patients projected, however, a total capital investment of \$10.3 billion in physical infrastructure, including leased space of \$3.4 billion, will be needed to meet demand.

¹ Section 330 of the Public Health Service Act is the authorizing legislation for the Health Center Program. Section 330 health centers receive grants under the Health Center Program and are also sometimes referred to as “federally-funded health centers” or “grantees.”

² A federally qualified health center (FQHC) is a type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes.

For health center-owned projects, respondents have identified and secured funding for only 37% of the cost of planned projects. Extrapolating to the full universe of health centers nationally, total secured capital development funding is likely at most \$2.1 billion, leaving a funding gap of \$3 billion to accommodate patient growth needs in health center-owned facilities. To reach the 32 million patient goal, a funding gap of at least \$4.8 billion likely exists for owned facilities.

The table below summarizes the national community health center project plans and funding needs.

Community Health Center Capital Project Plans and Funding Needs 2014-2018

	398 National FQHC Respondents	1,200 National FQHCs Planned Projects	1,200 National FQHCs Needed Growth
Additional Projected Patient Capacity	2 Million	5.9 Million	7.9 Million
Total Projected Patient Capacity	26 Million	30 Million	32 Million
Projected Capital Project Costs (Including Leased Facilities)	\$2.6 Billion	\$7.7 Billion	\$10.3 Billion
Projected Capital Project Costs (Owned Only)	\$1.7 Billion	\$5.1 Billion	\$6.9 Billion
Funding Gap (Cost Less Secured Funding for Owned Only)	\$1.1 Billion	\$3 Billion	\$4.8 Billion
Square Footage to be Built, Renovated, or Expanded (Owned Only)	4.8 Million	14.4 Million	19.3 Million

Capital Project Plans:

Responding health centers reported plans to initiate 528 capital projects which, when extrapolated to the full grantee list, equates to over 1,500 projects nationally.

The following table shows that of the estimated \$5.1 billion in spending for health center owned capital projects, the majority of funding required (\$4.1 billion or 80%) is for actual construction costs—whether for new construction, renovation or expansion of space. Construction costs represented 84% of projected spending in Capital Link’s 2012 national capital needs assessment. Equipment expenses comprise another 11% of total funds needed—slightly more than 8% in the last assessment, while the 5% allocated for refinancing existing debt in the latest study is considerably more than the 1% figure included in the prior one.

Components of Planned Capital Projects

Project Component	Respondent Capital Plans by Component	Percent of Total Cost	Extrapolated All CHC Capital Plans 2013-2018
Construction/Hard Costs	\$688 Million	80%	\$4.1 Billion
Equipment Purchase	\$91 Million	11%	\$541 Million
Refinance Existing Facilities	\$41 Million	5%	\$246 Million
Leasehold Improvements	\$29 Million	3%	\$172 Million
HIT or EMR Purchase	\$14 Million	2%	\$82 Million
Purchase Land/Building	\$1 Million	0%	\$6 Million
Total Project Size	\$863 Million	100%	\$5.1 Billion

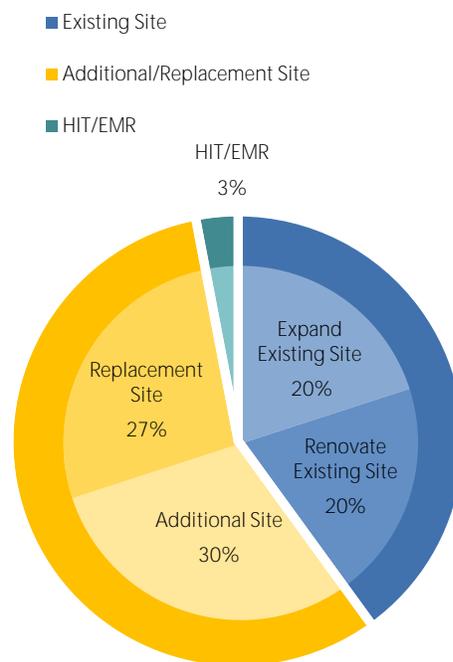
The breakdown of planned capital projects by type is highlighted in the accompanying chart. The proposed construction of additional or replacement sites, at 57% of all planned projects, outpaces the planned expansion or renovation of existing buildings, which comprise 40% of projected capital plans. Health Information Technology (HIT) and Electronic Medical Records (EMR) system investments represent only 3% of planned projects.

The average project size, estimated at \$3.2 million in this assessment, is less than the \$3.8 million figure forecast in the assessment completed in 2012. The change is not surprising given that most of the larger capital grants are expected to be done by the end of 2015.

Projected Funding Sources:

Of the \$1.7 billion in projects identified by the sample group, 37% of funding (\$625 million), or a total of \$2.1 billion when extrapolated to the full universe of health centers, was reported as secured. Over \$1 billion, or almost 50% of that funding, is expected to come from a combination of state grants, equity, and fundraising. Conversely, only 8% (\$175 million) of secured funding is identified as federal or other grant support. Details are provided in the Projected Secured Funding Sources table on the following page.

Type of Capital Project Planned



Projected Secured Funding Sources

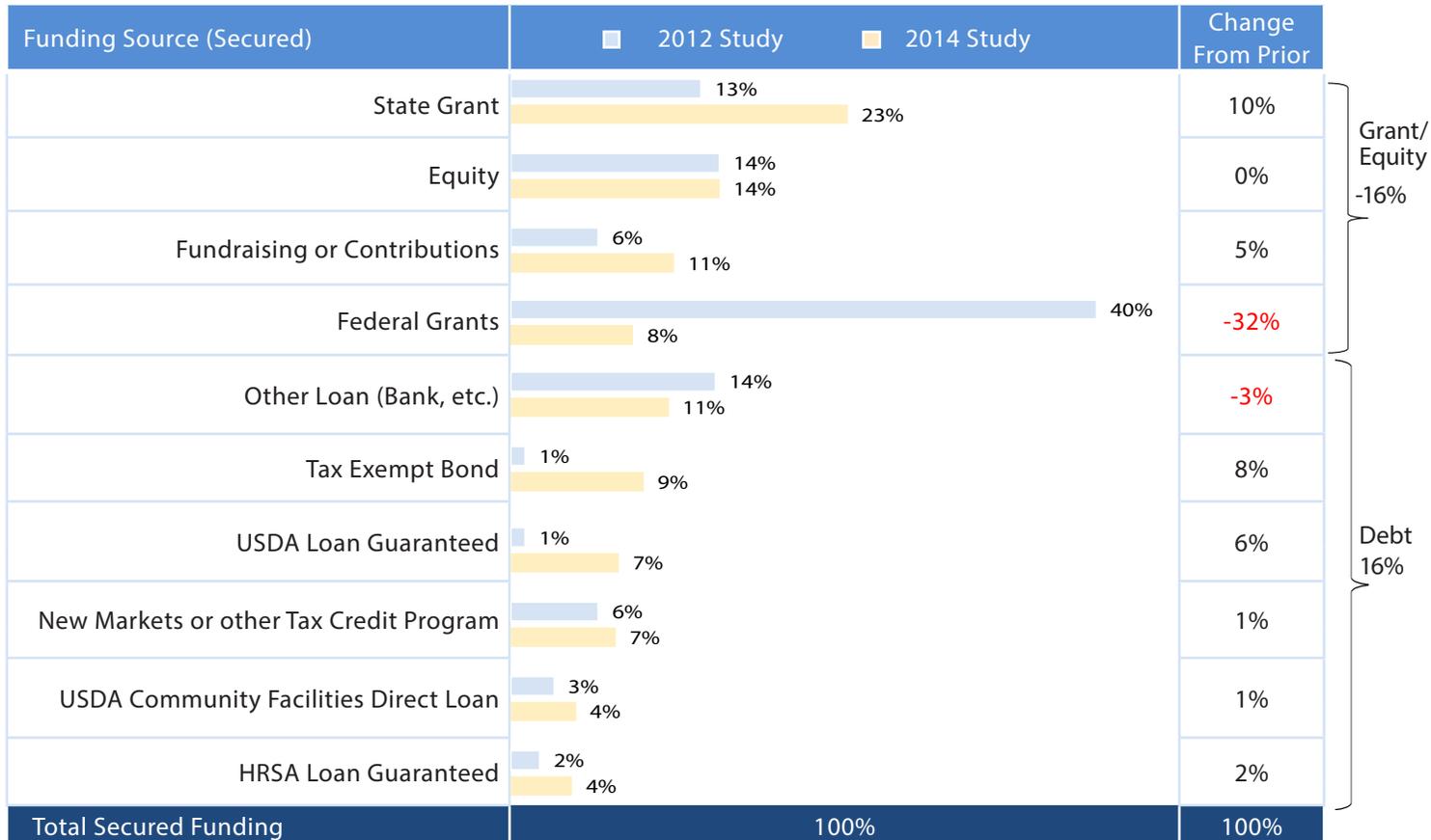
	Funding Source (Secured) In Millions \$	Sample Health Centers \$ Millions	Extrapolated to All Health Centers \$ Millions	% of Total Secured Funding
50%	State Grant	\$143.8	\$480.7	23%
	Equity	\$89.2	\$298.2	14%
	Fundraising or Contributions	\$69.8	\$233.2	11%
	Other Loan (Bank, etc.)	\$67.5	\$225.7	11%
	Tax-Exempt Bond	\$56.8	\$189.8	9%
	Federal Grants	\$52.4	\$175.1	8%
	USDA Loan Guaranteed	\$46.2	\$154.5	7%
	New Markets or other Tax Credit Program	\$44.9	\$150.0	7%
	USDA Community Facilities Direct Loan	\$28.0	\$93.7	4%
	HRSA Loan Guaranteed	\$26.3	\$87.8	4%
	Total Secured Funding	\$625.1	\$2.1 Billion	100%

The relatively small amount of funding projected from federal/other grants represents the most significant change from the prior assessment. In the 2012 study, health centers reported 40% of all secured funding was from federal sources, largely driven by the \$2 billion in HRSA capital grants made available through the American Recovery and Reinvestment Act (ARRA) and the Affordable Care Act (ACA)³ between 2009 and when the 2012 assessment was completed. The precipitous decline in federal capital grant support could have a significant negative impact on health centers' ability to complete capital projects if they are unable to successfully access a different mix of funding sources, including state grants, equity (i.e. health center cash reserves), fundraising, and contributions. Given the challenges facing state budgets, health centers' abilities to secure significant funds from states may be more limited than hoped. In addition, the fact that resources available through the HRSA Loan Guarantee Program have largely been expended points to the need for alternative funding sources to fill this gap as well.

The importance of tax-exempt bonds as an increasingly larger proportion of health center capital project funding should also be noted. While tax-exempt bonds comprised 1% of secured funding in the prior study, that figure has jumped to 9% in the recent assessment. The table on the following page provides a comparison of secured funding sources for the current assessment vs. the prior one, highlighting that total grant equity sources now comprise 17% less of overall secured funding.

³ A total of \$3 billion in HRSA capital grants were authorized as part of ARRA and the ACA.

Secured Funding Sources FY14 Assessment vs. FY12

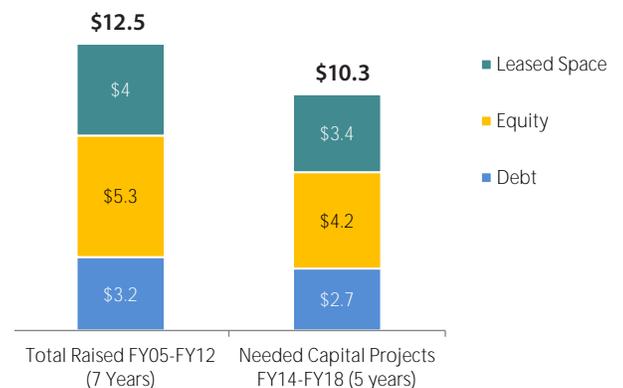


Growth in Capital Investments in Facilities:

From FY05 through FY12, health centers invested approximately \$8.5 billion in their physical infrastructure, with approximately \$3.2 billion (37%) coming from debt sources and \$5.3 billion (63%) from grants or health center equity. In addition, leased capital assets increased by almost \$4 billion.

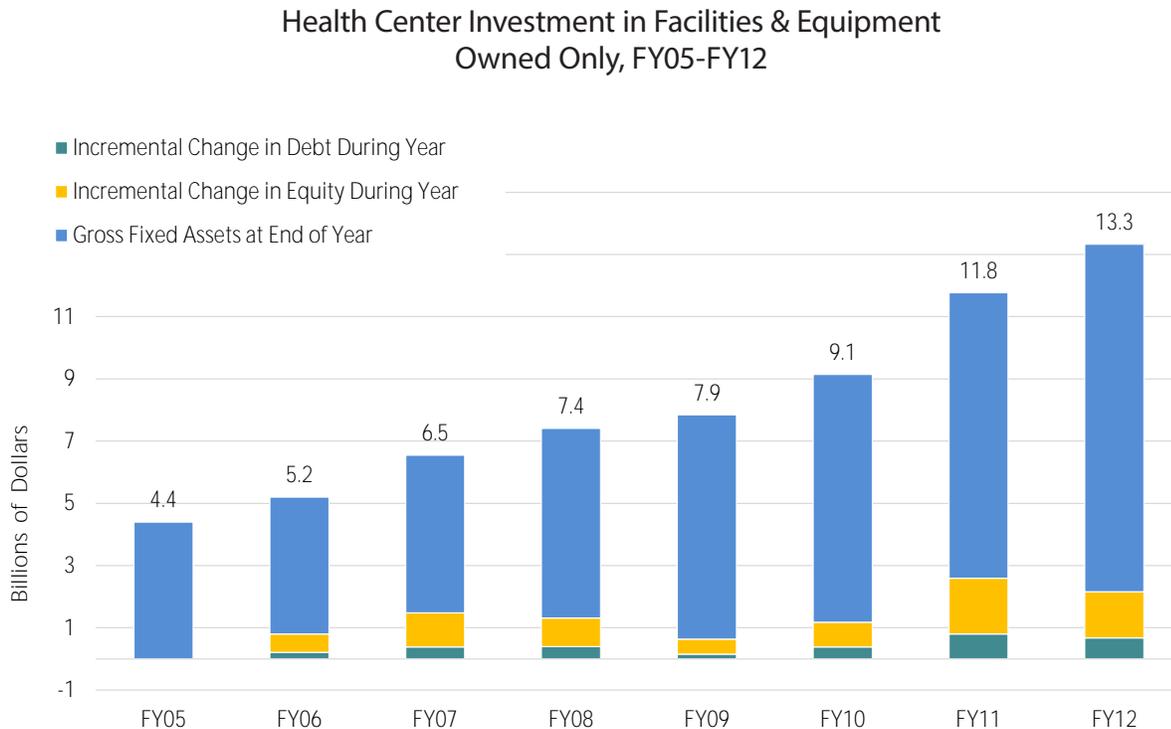
Notably, about 37% (\$2 billion of the \$5.3 billion) of the equity increase between FY05 and FY12 resulted from one-time HRSA capital grant awards. Therefore, achieving comparable levels of equity investment in the coming period may be challenging. Health centers may need to rely more heavily on debt to finance their projects and will also need to seek private sector grants through capital campaigns, foundations, and other charitable sources.

Sources of Fixed Asset/Property, Plant & Equipment Growth



Growth in Health Center Property, Plant & Equipment:

The following chart illustrates the increases in gross fixed assets as well as the annual incremental changes in debt and equity between FY05 and FY12. The significant increases in FY10-FY12 clearly reflect the impact of the HRSA capital grants that were awarded during this period.



Growth in Health Center Facilities, Including Leased Property:

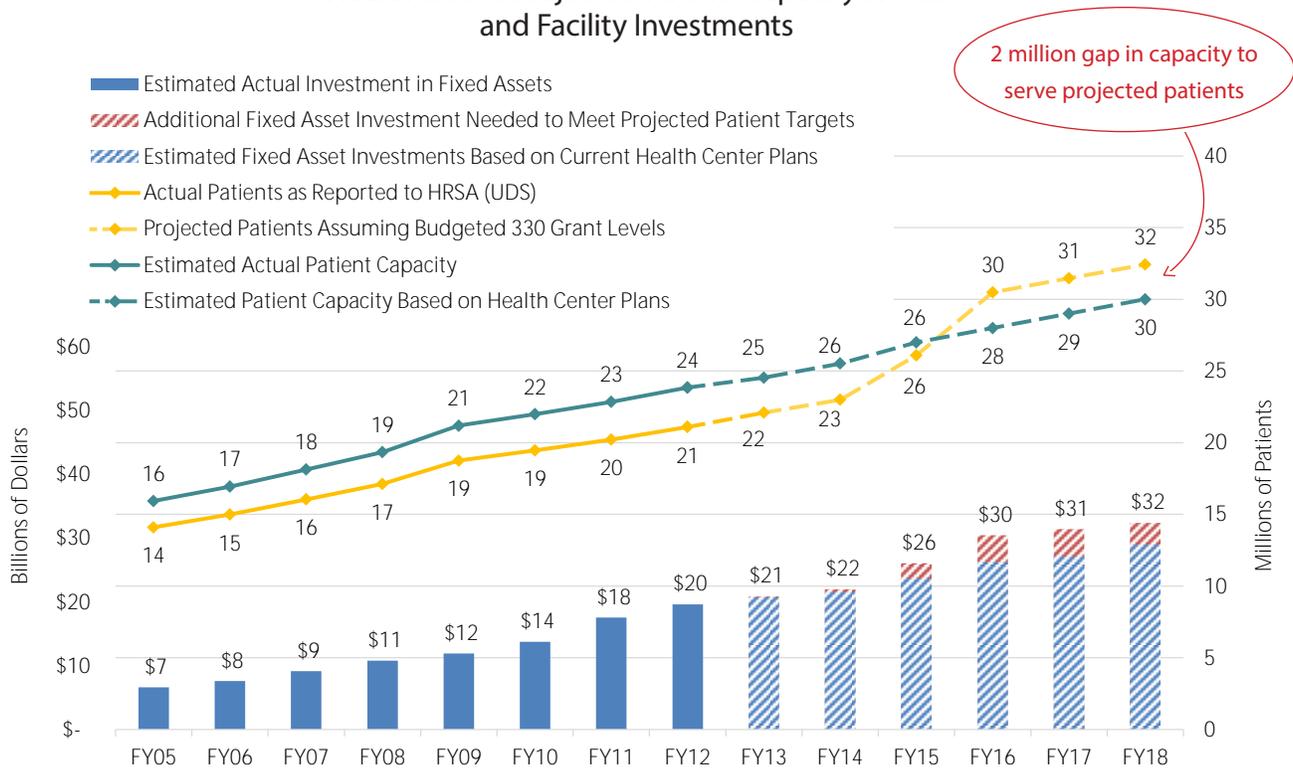
Capital Link's research indicates health centers own approximately two-thirds of their facility space and lease the other third. Assuming the ratio is the same going forward and that the costs of constructing or renovating leased space is similar to that of owned space, the following chart shows the estimated total investment in health center-occupied space for FY05-FY18 under two scenarios.

The baseline forecast shows a \$29 billion overall investment in gross fixed assets, including leased property, by FY18 based on the \$5.1 investment in planned health center-owned projects. As noted on the chart, that level of investment would increase capacity to serve 28-30 million patients annually over the next several years. However, the estimated patient need, also presented on the chart, is expected to rise to 30-32 million over the period, assuming the maintenance of currently-authorized levels of health center federal operating support through FY16 with modest increases thereafter.

The chart clearly shows that absent a greater investment in physical capacity than currently planned by health centers, they will likely not have the space to accommodate the level of patients expected beginning in FY16. A minimum additional investment in health center facilities totaling \$2.6 billion, including leased space, would be necessary between FY15 and FY18 to accommodate the additional two million patients

expected. The more aggressive capital investment projection shows a need for a \$32 billion investment in health center occupied space by 2018 - an increase of \$10.3 billion over FY14 levels.

Health Center Projected Patient Capacity Needs and Facility Investments



Note: Estimated total gross Fixed Assets includes Leased Assets and are based on Estimated Patients. Dashes indicate projected amounts.

Health centers must also continue to invest in existing facilities especially considering that more than 25% of health center buildings are over 30 years old.⁴ In fact, of the responding health centers, 35% said some of their locations (aside from those already discussed in the capital projects section) require maintenance or upgrades in the near future for their continued use. Any capital investments health centers make in maintaining current facilities could squeeze out investment in new sites or expanded facilities, thus inhibiting their overall ability to grow.

Co-Location, Collaboration, and Merger Plans:

Approximately 40% of planned projects involved co-location or collaborations, most often with schools, other human service providers, housing, and health departments. These partnerships could offer interesting potential funding or financing options through working with foundations, Community Development Financial Institutions (CDFIs), or others interested in supporting particular industries or programs.

In addition, 12% of respondents are contemplating mergers or acquisitions with other health centers or organizations. Any such consolidations could have implications for capital funding and working capital needs, which health centers must plan for and address.

⁴ Capital Link, *Capital Plans and Needs of Health Centers: A National Perspective* (2012), 11.

Growth Capital Requirements:

Health center growth and/or significant practice model changes often result in liquidity challenges that require financing support. Twenty-eight percent of the study's respondents anticipate a need for such growth capital in the next five years above and beyond their current lines of credit. As outlined in the following chart, 16% of health centers anticipate a funding need associated with implementing the Patient-Centered Medical Home (PCMH) model of care and 15% expect losses when starting a new site.

Nine percent of responding health centers listed a need for growth capital to integrate behavioral health services, while 8% of respondents required assistance to participate in Accountable Care Organizations (ACOs). Interestingly, only 5% of all respondents anticipated a need for financing assistance to cover the losses involved in transitioning to a new payment system and only 2% projected a need associated with Electronic Health Record implementation.

Respondents Expressing a Need for Growth Capital	% of respondents who answered yes
Cover costs associated with implementing PCMH model of care	16%
Cover losses during start-up of a new site	15%
Integration of Behavioral Health	9%
Develop/participate in Accountable Care Organization (ACO)	8%
Acquire/merge with another organization	6%
Create sufficient reserves for risk-based contracting	5%
Cover losses associated with transitioning to new payment system	5%
Cover losses associated with EHR implementation	2%
Total Respondents Expressing Any Need for Growth Capital	28%

Growth Readiness:

Significant planning, market analysis, and financial assessments are necessary before initiating capital projects. Most of the responding health centers had completed some planning processes necessary for facility growth, particularly in the analysis of patient visits and capacity and market needs as outlined in the following table.

Capital Development Pre-Planning Processes Conducted by Health Center	Percent
Analysis of Patient Visits	65%
Needs/Market Assessment	59%
Analysis of Patient Capacity	54%
Community Outreach	52%
Analysis of Debt Capacity	38%

Note: total exceeds 100% due to multiple responses.

A number of planning activities related to specific capital projects have also been completed, predominantly space planning and site selection as summarized below. However, additional work involving financial projections, business plans, architectural design, site control, and financing options analyses will need to be completed for projects to move forward in a timely fashion.

Planning Activities Conducted for Specific Capital Projects	Percent
Space Plan/Room Requirements	52%
Site Selection	43%
Financial Projections	37%
Architectural Design	33%
Business Plan Development	29%
Site Control	19%
Financing Options Analyses	17%
Capital Campaign Feasibility Analysis	13%

Note: total exceeds 100% due to multiple responses.

Challenges to Capital Development Growth:

Respondents rated the building of equity and securing grant funding—essential ingredients for successful capital projects—as their main challenges to growth. They also listed limited staff time to work on capital projects and the need for more fundraising as other main challenges. Their summary responses are included in the following table.

Main Challenges to Meeting Capital Needs	Percent
Building Equity/Cash Reserves	46%
Securing Grant Funding	44%
Staff Time to Work on Project	38%
Fundraising	38%
Fluctuations in Cash Flow	23%
Securing Loan Funding	21%
Payer Mix	19%

Note: total exceeds 100% due to multiple responses.

In addition to the challenges of securing funding and allocating sufficient staff time to work on capital expansion, health centers must also recognize that projects are often more expensive and take longer to plan and build than anticipated.

Conclusion

In summary, this study offers the following insights, which may be useful to health centers, policy-makers, and funders as they consider challenges associated with health center growth:

1. Health centers are planning to undertake capital projects totaling \$5.1 billion for which the funding gap is \$3 billion. Raising sufficient capital to accomplish the planned growth will be extremely challenging particularly since federal grant funding will be less available.
2. Even if those projects can be fully-funded and built, the additional capacity will not be sufficient to accommodate the number of patients anticipated to arise from the ACA. A capital investment of \$6.9 billion for health center-owned facilities, of which \$4.8 billion is not yet secured, is needed. An additional leased facility investment of \$3.4 billion, or a total investment of \$10.3 billion, is required to build capacity to serve the patient growth target of 32 million by 2018.
3. Health centers are beginning to look beyond traditional brick and mortar financing needs to secure capital required to support growth. They are also increasingly considering collaborations and co-locations to provide expansion opportunities.
4. Aggressive growth plans necessitate careful planning to ensure successful projects and ongoing health center viability. Investing time and effort in planning for expansion will pay off in the long-term.

Appendix A

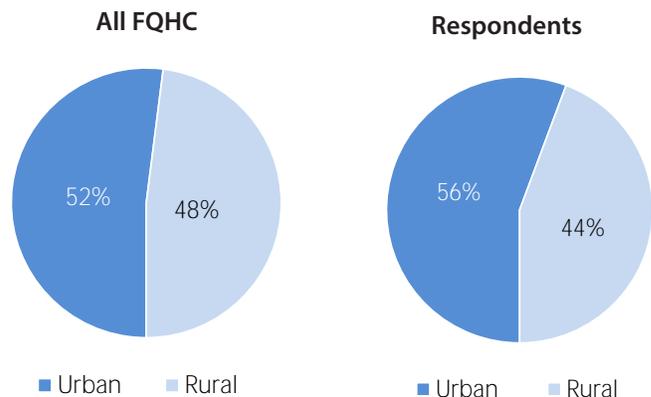
Respondent Profile:

An analysis was undertaken to ensure the health center sample included in the study had key characteristics (rural vs. urban location, geographical region, and operating budget size) that were consistent with the entire universe of 2012 UDS health center grantees.

The charts on the following page indicate the distribution of respondents is representative of the universe of health centers generally, noting the following differences:

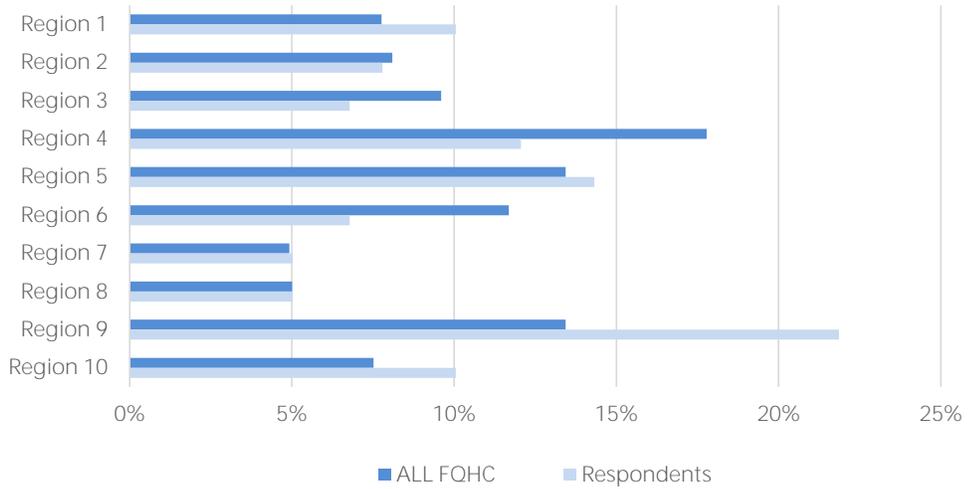
- The sample had a slightly lower percentage of rural health centers and a slightly higher proportion of urban health centers than the grantee universe. See charts to the right.
- Each HRSA Region was well-represented in the sample although the sample had a higher percentage of participants than the proportion of grantees for some regions, notably Regions 1, 9, and 10. Likewise, for Regions 3, 4, and 6, the proportion of participants was lower in the sample than in the full universe. In all others, which includes Regions 2, 5, 7, and 8, the proportion of participants was very similar to the proportion of grantees. Note that HRSA Regions are defined on page 13 of this report.
- Larger health centers, defined as those with an operating budget size of \$10 million or more, had a relatively stronger representation in the sample while smaller health centers responded at a lower rate. This is not surprising since larger health centers are generally more active in the building and financing of capital projects.

Respondents vs. All Grantees by Location:
Urban vs. Rural

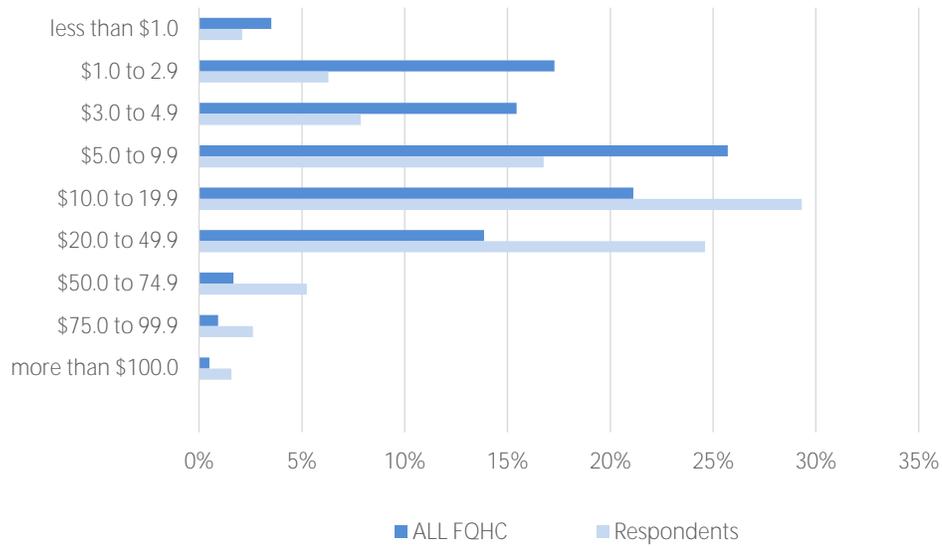


Source: HRSA 2012 UDS FQHC List

Respondents vs. All Grantees by Region



Respondents vs. All Grantees by Operating Budget Size



Methodology:

Online capital needs assessments were sent in the fall of 2013 via e-mail to the CEOs, COOs, and CFOs of approximately 1,200 HRSA grantees and Look-Alikes. Health centers received three notifications and reminders to participate. The availability of the national capital needs assessment was publicized in Capital Link's newsletter, website, PCA, and NACHC websites where possible, and through other channels to ensure all health centers were aware of the project and invited to participate. All PCAs and NACHC were personally contacted to encourage their member centers to respond. Additional follow-up e-mails were sent and access to a shorter assessment was provided to those states with low participation to ensure a representative national sample of capital needs information was collected. These methods netted 296 direct health center responses.

Internal Capital Link documents and the organization's financial database were reviewed for additional completed, current, and potential projects to determine status and outstanding capital needs. For health centers that had listed projects or capital needs in Capital Link's last capital needs assessment and/or for those that received Capital Development-Building Capacity (CD-BC) grants from HRSA, progress on those projects was reviewed where information was publicly available to determine remaining funding gap, and, as needed, centers were contacted to determine their current project status and funding gap. One hundred and two unique health center responses were collected in this manner.

When incomplete project data was provided or available, Capital Link project staff contacted individual health centers and/or estimated project costs and funding gaps. Capital Link's project cost report was used to estimate building costs by state and internal guidelines and industry standards were used for square footage needed based on projected staff and/or full-time equivalent employee additions⁵.

HRSA Grantee Regions:

Region 1: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Region 2: New Jersey, New York, Puerto Rico, and the Virgin Islands

Region 3: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia

Region 4: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee

Region 5: Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

Region 6: Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

Region 7: Iowa, Kansas, Missouri, and Nebraska

Region 8: Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming

Region 9: Arizona, California, Hawaii, Nevada, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Marshall Islands, and Republic of Palau

Region 10: Alaska, Idaho, Oregon, and Washington

⁵ Capital Link, *Estimating Capital Project Costs for Health Centers* (June, 2013), 7.