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Rural HEALTH NEWS

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Finding the Funds for Rural Health

By Thomas D. Rowley

Folks around Uvalde, Texas—a town of 16,000, an hour or so from Mexico, San Antonio, and the nearest interstate—have a new primary care health facility. And it only took seven years, half a dozen funders, and an act of Congress to get it. Count the folks in Uvalde among the fortunate few.

New Wing of Uvalde's Community Health Clinic

Indeed, getting money to update rural health facilities (many of which were built with Hill-Burton funds in the 1950s) is one of the bigger hurdles faced by rural health care providers. Terry Hill, director of the National Rural Health Resource Center, says, "If you ask rural hospital administrators," and he's asked hundreds of them, "they'll tell you that access to capital is one of their top concerns." Mitchell Patridge of Meridian Capital, a lender specializing in health care financing, puts it more bluntly: "The vast majority of rural hospitals can't get a loan."

For Rachel Gonzales Hanson, CEO for Uvalde's Community Health Development, getting a new wing added to her facility was an education in the intricacies of rural capital funding. She found her way through a maze of Federal programs, private lenders, and foundations—a lesson on funding a capital project from beginning to end.

Of course, capital is only a means to an end—quality health care. And without capital to update their buildings and equipment, many rural facilities see their ability to provide quality health care diminish. In worst case scenarios, dilapidated and often dangerous conditions go uncorrected. (Some rural hospitals have no fire sprinkler systems; some have no protective lead lining in the walls of X-ray rooms.) Up-to-date technology and equipment can be unavailable. And health care professionals are difficult to attract and keep. As a result, patients drive to the city for care, and their local hospital—usually the largest or second largest employer in town—loses its ability to anchor the local economy. And thus begins a downward spiral.

Part of the problem comes simply from being rural—fixed costs, low volume, few economies of scale, poor community economic performance, mergers in the financial industry that move lending decisions out of the local community, and the like. Part comes from Medicare reimbursement policies that pay rural providers lower rates than urban providers for the same services, based on the arguably incorrect assumption that everything costs less in rural areas. The result is low, and often negative, operating margins that make it almost impossible to obtain loans—from private as well as governmental lenders—and make it difficult to repay the loans when and if they are obtainable. According to participants in a recent meeting of rural hospital administrators, the latter may well be the bigger problem. As Tommy Mullins, a hospital administrator in Madison, West Virginia, puts it, "What good is access to capital if you have trouble making the payments?" Adds consultant J. Michael Boyd, "If you take away the risk [of default], anybody will give you money."

Not surprisingly then, a 1997 study by the consulting firm Mathematica concluded that 67 percent of the rural hospitals surveyed were unable to update their

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buildings and equipment because of insufficient access to capital. In addition, Medicare Cost Report shows that rural hospitals tend to have lower levels of debt and older facilities than their urban counterparts, meaning that rural hospitals are borrowing less to update their facilities. And while that may be due to either a lack of capital or an inability to earn enough on the investment to justify making it, either way you cut it, it comes down to money—and rural health care facilities simply don't have enough.

Consequently, things are brewing at the federal level, and in several states, that could make capital for rural health care facilities easier to come by. First, a national survey is being planned to get a more complete picture and up-to-date estimates of the capital needs of rural hospitals. The survey will be conducted by the Rural Hospital Capital Access Workgroup—a group of governmental officials, hospital administrators, and banking industry executives under the auspices of the Federal Office of Rural Health Policy—in conjunction with state hospital associations. According to Jerry Coopey, chair of the workgroup, the survey will identify the capital needs for new construction, renovation, equipment, and so forth. The results will shine new light on an issue that everyone agrees is a problem, but one whose magnitude is hard to pin down. In so doing, "the information," says Coopey, "will be most helpful to decision-makers in government and industry, as well as researchers in the field."

On the legislative front, a bill presented in the last Senate session would have created a revolving loan program that lends to rural health facilities, sells the loan on the open market, and uses the sale proceeds to replenish the loan pool. The upper limit on loans in the program would be $5 million per facility, with a program total of $250 million per year. Planning grants of up to $50,000 would also be made available. The beauty of the program is that it requires only a one-time appropriation to create an ongoing source of funds. Unfortunately, the proposed program—which was part of Senate Bill 2735, known as the Health Care Access and Rural Equality Act of 2000 and sponsored by Senator Conrad of North Dakota—died with the close of the 106th Congress. According to Neleen Eisenger in Senator Conrad's office, however, the Senator will reintroduce it in the 107th Congress.

Finally, the Department of Health and Human Services National Advisory Committee on Rural Health called for a Rural Hospital Capital Need Loan Program in its FY 2000 recommendations. Such a program would lend funds to licensed acute care rural hospitals and allow them to repay part of the loan by delivering indigent care.

None of which is to say that programs don't already exist to fund rural health care. Quite a few do—in both the public and private sectors. At the federal level, the Department of Housing and Urban Development runs the 242 Program, while the USDA runs the Community Facilities Program, and the Small Business Administration runs several loan programs for for-profit rural hospitals. Foundations such as The Robert Wood Johnson Foundation offer another source. There are also several states that have developed capital programs.

The HUD 242 Program

In its 30 years of existence, the Federal Housing Administration's Hospital Mortgage Insurance Program (commonly referred to as the HUD 242 Program) has insured more than 300 hospital mortgages for a total of more than $8.6 billion. The program offers 90-percent loan-to-value mortgages and can be used to finance new construction, modernization, or equipment purchase. Just like FHA mortgage insurance on housing, the program enhances a borrower's creditworthiness by taking the risk out of lending. Consequently, loans are easier to come by, and at much better rates. Unfortunately, the program has not reached out to rural communities. That is now changing courtesy of the Medicare Rural Hospital Flexibility Program—authorized in the Balanced Budget Act of 1997. The program allows Medicare to certify certain hospitals as critical access hospitals (CAHs), which receive cost-based rather than formula-based reimbursement from Medicare for inpatient and outpatient Part A services. The change allows

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the hospitals to recoup capital costs and improve their bottom lines.

In an effort to get more help to rural facilities, HUD has also streamlined and eased its 242 process for applicants that are CAHs, doing such things as paying the bill for financial feasibility studies on behalf of CAH borrowers and working with them in partnership to ensure their long-term success—including hiring consultants to develop financial turnaround plans for hospitals in trouble. As Charles Davis, manager of HUD's Critical Access 242 Program and a rural hospital administrator for 30 years before that, put it, "As a rural hospital administrator, I simply couldn't afford the kind of help HUD is providing." Mary Ellen Schattman, Davis' boss and director of HUD's Office of Insured Health Care Facilities, describes the relationship this way: "We don't do matchmaking, but once the hospital and lender are married, we stand ready to help them with whatever they need. If hard times come, we'll be there."

HUD 242 Program
(202) 708-0599
www.hud.gov/fha/fhahospi.html

Critical Access Hospitals
Contact Charles Davis at
(202) 708-0614.

USDA Community Facilities Program

The Community Facilities Loans and Grants Program of the U.S. Department of Agriculture's Rural Housing Service provides direct loans, loan guarantees, and grants to develop essential rural community facilities in population areas of up to 20,000. Funds—which are available to public entities—may be used to construct, enlarge, or improve hospitals, clinics, ambulatory care centers, rehabilitation centers, and nursing homes, as well as other public safety and public services facilities. Costs for land, professional fees, and operating equipment may also be covered.

USDA Community Facilities Program
(202) 720-1490
www.rurdev.usda.gov.

SBA Loan Guarantees

The Small Business Administration also guarantees loans to for-profit health care providers in rural areas. One of its most popular programs, the Certified Development Company (504) Loan Program, works like this: a health care provider obtains a loan for 50 percent of the cost of land, buildings, and equipment from a bank, 40 percent—typically at a lower than market rate—from a certified development company (CDC), and puts up 10 percent itself. SBA then guarantees the portion of the loan held by the CDC. The loan limit is $1.25 million.

SBA Programs
www.sba.gov

In Montana, the Health Facility Authority (HFA) has come up with an innovative scheme for helping rural hospitals access capital. Since 1994, the authority has sold bonds on the open market to get capital for rural hospitals and has used funds in the state's permanent coal trust fund and treasurer's fund as surety to guarantee the bonds. As a result, small rural hospitals that, because of their size, would have trouble floating their own issues, have access to "A" rated, 20-year bonds at 4- to 5-percent interest rates.

The bonds, which can be used to pay for construction, renovation, expansion, and equipment, are typically in the $2 million range. Currently, $34 million in bonds is outstanding; the authority can issue up to $75 million. To date, there have been no defaults.

Texas is also using a somewhat unusual pool of money to provide rural hospitals with capital—tobacco settlement dollars. In 1999, the state legislature set aside $50 million from the tobacco settlement to create the Rural Health Facility Capital Improvement Program. Interest from the endowment provides a permanent annual grant of $2.2 million. That $2.2 million is then parceled out in grants and zero-interest loans to public hospitals in rural counties with fewer than 150,000 residents or in part of a county not classified as urbanized.

Eligible projects include improvements to existing facilities, construction of new facilities, and purchase of capital equipment. In its first year, 32 rural hospitals received funds; 97 applications totaling $9.5 million were received.

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Which brings us back to Uvalde, deep in the heart of rural south Texas. Known for its honey production and as the home of John Nance Garner, Uvalde County and its neighbors, Real and Edwards, are also known as persistent poverty counties, health practitioner shortage areas, and medically underserved areas. Not surprisingly then, before Uvalde County Clinic, Inc. (UCCI) was established in a trailer in 1984, residents often went to Mexico for medical care or waited until things got bad enough to go to the emergency room. And, again not surprisingly, demand for services soon outstripped UCCI's ability to provide them. Consequently, the agency moved into 4,000 square feet of space leased from the local hospital, but soon outgrew it as well. So, seven years ago, the board of directors began making plans to build a new facility. The question was how to pay for it. The answer: from a lot of pockets.

The new facility—a federally designated community/migrant health center—didn't use any of the state tobacco settlement dollars. It was built using monies from a slew of different sources—local, state, federal, and private. Getting that first check, however, wasn't so easy, according to Rachel Gonzales-Hanson, CEO of Community Health Development, Inc. (UCCI's new name)—the agency that runs the center. "It's hard enough being a rural provider," says Gonzales-Hanson. "It's even harder when you're not a hospital." According to her, hospitals—even rural ones—have more options when it comes to obtaining financing.

Nonetheless, Gonzales-Hanson and her colleagues went searching, and eventually succeeded. Although private foundations were not interested initially in funding a bricks-and-mortar project (the center fell $30,000 short of a required match to obtain $100,000 from one foundation that was interested), the center finally landed a grant from The Robert Wood Johnson Foundation to get the ball rolling. That was five years ago. Since then, the center's proponents raised the balance of the $2.1 million it needed to buy the land, build, and equip the new 18,000-square-foot facility and adjoining 1,800-square-foot administrative building. Contributions came in the form of $124,000 from the agency itself, a $650,000 grant from the Bureau of Primary Health Care, $280,328 in Community Development Block Grant money passed through the Uvalde County Commissioner's Court, $25,000 from the city of Uvalde, a $580,000 community facilities loan from USDA, an additional $40,000 grant from USDA, foundation funds totaling $420,000 (which were used to pay off 80 percent of the USDA loan), and $453,098 courtesy of Congressman Henry Bonilla, who inserted the line item in the federal budget.

How was the center able to tap so many pockets successfully? Gonzales-Hanson gives several reasons. Obviously, having Congressman Bonilla in their corner was key, or as she puts it rather mildly, "It helps to know your congressman." Indeed, Congressman Bonilla's commitment to his district, his strong interest in community/migrant health centers, and his position on the appropriations committee were all helpful on this project.

Finally, you have to be willing to put resources and passion into your grantwriting. Strapped as many rural entities are, this is not easy to do, but it is necessary. The Uvalde center hired a planning and development director to take charge of its fundraising effort.

The results of the effort—Our Health/Nuestro Centro de Salud—opened in February 2000. The facility houses a dental/oral health unit, an X-ray unit, and 20 exam rooms in the Henry Bonilla Primary Care Wing. Future plans include adding mental health services in an effort to create a comprehensive health care facility for patients. It's just possible that future plans may also include yet more fundraising, because according to Gonzales-Hanson, "You run out of space faster than you think."

Helping People with Health Care CHOICEs

A network of rural health care providers in Washington state has learned the value of working collaboratively.

The CHOICE Regional Health Network is a five-year-old nonprofit consortium of public hospitals, local public health departments, physicians, and other practitioners serving five counties in the South Puget Sound region of Washington. The network members came together to try to increase access to care, minimize duplication of efforts, and improve accountability standards.

"Competition creates inefficiencies rural areas can no longer sustain," says Maryann Welch, director of Grays Harbor Public Health and Social Services Department.

One of the many programs offered by CHOICE is the Regional Access Program (RAP), which coordinates with community-based organizations, primarily in rural areas, to increase access to health care services. Under that program, access coordinators meet one-on-one with people near their home to answer health insurance questions, inform them of health plan choices, and offer advice on how to select a primary care physician.

Information submitted by Virginia Brooks. For more information, contact CHOICE at (360) 493-5683.

Improving Insurance Coverage for Migrant Children

Providing health insurance to the children of migrant farmworkers is a difficult task, but one community in Pennsylvania is trying to remedy that situation.

Indeed, state officials estimate that some 8,000 children of migrant farmworker families have low levels of enrollment in any health insurance program, despite the fact that they may be eligible for coverage through the State Children's Health Insurance Program (SCHIP) and Medical Assistance Program (MA). The frequent moves of such families, in search of seasonal and temporary agricultural employment, inhibit traditional efforts to enroll the children.

To meet that need, the Pennsylvania Office of Rural Health (with a grant from HHS) has unveiled Operation Enroll. The program will attempt to assess the insurance status and eligibility of at least 90 percent of the migrant farmworker children at each migrant farmworker site in the state and then help eligible families to apply for either the SCHIP or MA.

Information submitted by Betsy Nixon. For more information, contact the Pennsylvania Office of Rural Health at (814) 863-8214.

Creating a Culturally Sensitive Network

The small towns and villages of St. Joseph County, Michigan, are home to a large Amish population and a burgeoning Hispanic community, but access to needed health care services, especially for women, is lacking.

To meet that need, a network of portable clinics has been established to reach out to the underserved. Project organizers say these clinics will help address the problem by providing more culturally sensitive care. A community needs assessment found that the Amish women and their Hispanic counterparts felt most comfortable with a different kind of primary preventive health care service. They would like, when possible, for services to be delivered by women, and they would like to pay for these services with cash. Different though they are from each other, the Amish and Hispanic residents of the county share at least one thing in common: many are uninsured or underinsured. The Amish, for cultural reasons; the Hispanics, for economic reasons—most work in small factories where dependent insurance coverage is not an option.

In response, providers—with the help and support of community residents—will open a network of portable clinics located in Amish homes, the local health department, and a rural health clinic. All those

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involved in the year-long planning process believe local providers can provide well-staffed, culturally sensitive, locally delivered health care for the target populations for $30 a visit.

Information submitted by Jody Ross. To learn more, call (517) 332-4537 or send an e-mail to rossjoan@msu.edu.

Virtual Health in Alaska

In October 2000, an historic meeting of agencies representing the Alaska health care system took place.

Fifty-three individuals representing 44 agencies came together under the auspices of the Alaska Native Tribal Health Consortium and the Alaska Center for Rural Health to discuss the potential for using telecommunications technology to improve the health of Alaskans.

The event began with a small grant from the National Rural Health Association and a big question: "Can Alaska's intimidating geography be somewhat 'neutralized' as an impediment to communications between health agencies through the use of modern telecommunications technology?" In other words, can a virtual association—one that thrives in the universe of electrons and radio waves—be constructed that will do what health agencies in other states take for granted because they have a road system: meet, share information, and take action? The answer, according to participants: yes. As a result, efforts to create such an entity are continuing.

Information submitted by Denny Degross. He can be contacted at fndpd@aurora.alaska.edu.

3R Net Meeting Examines Critical Issues

Getting and keeping health care professionals in rural areas is no easy task.

The National Rural Recruitment and Retention Network (3R Net), however, is helping to change that. The not-for-profit organization assists health professionals in locating health care providers in practices throughout rural America. At its annual meeting, held in Albuquerque in November, 3R Net examined several issues critical to its mission.

Denise Denton, director of the Colorado Rural Health Resource Center, spoke on the importance of collaboration, pointing out that workforce issues overlap with the missions of many different types of organizations, such as offices of rural health, primary care associations, professional associations, and training programs. She also noted that recruitment is essentially a local activity; consequently, community representatives need to be brought into the process if it is to be effective. "Too often," says Denton, "the community is the last to be consulted."

Finally, 3R Net is developing the second edition of its database-driven Web site. Changes to the site will enable local communities to edit their own data, add images and logos (such as the National Health Service Corps), and indicate whether they belong to networks or have resources such as community health centers. Health centers, hospitals, and clinics will be able to feature their practices and communities.

3R Net will hold its mid-year meeting in conjunction with the National Rural Health Association's Rural Health Conference in Dallas on May 22, 2001.

For more information, contact 3R Net at (800) 787-2512 or info@3rnet.org.

Brand Takes Helm of ORHP

Dr. Marcia Brand takes over as the new director of the Office of Rural Health Policy when the interest and attention on rural health issues is at an all-time high.

Dr. Claude Earl Fox, administrator of the Health Resources and Services Administration, tapped Dr. Brand for the job on January 2, 2001, to succeed Dr. Wayne Myers, who retired late last year.

"We're in good hands with Marcia taking over the Office of Rural Health Policy," Dr. Fox said. "She brings a wealth of experience to that job in terms of both policy and the program administration."

Dr. Brand assumes leadership of the office at a unique time. Interest in rural health continues to grow. The Medicare Payment Advisory Commission, which advises the department and the Congress on Medicare payment issues, will release a report in June that focuses on key Medicare payment issues and their impact on rural communities. Congress also passed a package of Medicare and Medicaid revisions late last year that included significant rural provisions.

"This is an exciting time for the office," Dr. Brand said. "There's been a lot of interest in rural issues both at the department level and with the Congress. The MedPAC report should shed light on some key rural Medicare issues. At the same time, our grant programs continue to draw a record number of applicants and play a critical role in helping to build and sustain the rural health care delivery system."

In her role as director, Dr. Brand will oversee a 22-person staff at ORHP, which serves as the focal point for rural issues within the Department of Health and Human Services.

Research Center Awards

The Office of Rural Health Policy has given awards to six rural health research centers to provide policy-relevant research on rural health issues for FY 2001–2004. The awards went to three previously funded centers—the University of North Carolina, the University of Washington, and the Walsh Center for Rural Health Analysis in Maryland—and three new ones—the University of Nebraska, the University of South Carolina, and Texas A&M University. The centers in North Carolina, Maryland, and Nebraska—also known as Policy Analytic Centers—will focus on Medicare and Medicaid. The remaining centers—General Centers—will focus on minority health issues (South Carolina and Texas) and workforce issues (Washington).

Initiated in 1988, the Rural Health Research Center (RHRC) Program, administered by the Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services, aims to increase the amount of high-quality, policy-relevant, rural health services research. The centers study critical concerns facing rural communities in their quest to secure adequate, affordable, high-quality health services. In turn, the Office of Rural Health Policy uses the centers' findings to educate a wide audience of national, state, and local decision-makers concerned with rural health issues.

The ORHP Web site (www.ruralhealth.hrsa.gov) provides ordering information and a list of reports from the centers.

For additional information, contact Joan F. Van Nostrand, director of Research, Office of Rural Health Policy, at (301) 443-0835.

New Project To Examine Rural Local Public Health Agencies

While research abounds about public health in general, little has been done that focuses on specific rural issues, but that's about to change thanks to new work by the National Association of County and City Health Officials (NACCHO).

The group, a nonprofit membership organization serving all of the nearly 3,000 local health departments nationwide, is reexamining much of its survey data to focus on rural issues. This work is expected to produce the first real rural-specific analysis of public health infrastructure.

"This opens a whole new door for us," said Michael Meit of NACCHO. "So many of our constituents are in rural areas, and this will enable us to better understand their resources, their backgrounds, and their needs."

NACCHO's rural health project has been spurred by the need to better define and serve rural public health departments across the nation. Funded by the Federal Office of Rural Health Policy, the project seeks to categorize local public health agencies into a rural/nonrural classification. This categorization will allow NACCHO to examine and then address differences in infrastructure needs among urban and rural health departments. By more effectively portraying the rural public health infrastructure, NACCHO hopes to better advocate on behalf of rural public health agencies and develop tools and resources that speak to their unique needs and concerns.

Several NACCHO surveys will be analyzed using the rural/nonrural classification designated by the Office of Management and Budjet (OMB). The findings from these analyses will be disseminated in a variety of ways. Initially, a *NACCHO Research Brief* will highlight the main findings. This will be followed by a more detailed report outlining the state of rural health departments in the United States today. These publications are forthcoming.

NACCHO provides education, information, research, and technical assistance to local health departments and facilitates partnerships among local, state, and federal agencies in order to promote and strengthen public health.

For more information, contact Ms. Anjum Hajat at (202) 783-5550 x253 or ahajat@naccho.org.