

**Rural Hospital Access to Capital:  
Issues and Recommendations**

*Working Paper Series*

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## EXECUTIVE SUMMARY

There is a growing concern that rural hospitals are having difficulty obtaining finances to modernize buildings and equipment (National Advisory Committee on Rural Health, FY 2000 Recommendation). Some of the more traditional sources of funding (e.g., short-term bridge loans, charitable donations, tax credits and public fund-raising efforts) are not as available as they once were. Even the availability of loans through bond sales, the most popular source of debt financing today, has been contracting since the late 1990's for all facilities but those with the very highest of credit ratings.

The likelihood that a rural hospital will be able to obtain capital from external sources to support a major project (e.g., modernization, renovation, new construction or purchase of major equipment) depends heavily on the following three factors:

- The perceived ability of the borrower to honor the loan agreement and meet its financial obligations (i.e., repay the loan);
- The ability of the lender to cover the fixed costs of the loan process and still meet profitability goals; and
- In the absence of demonstrated ability to repay, the ability of the borrower to obtain mortgage insurance to buffer the lender from possible risk of default.

According to the Health Care Financing Study Group, approximately 60 percent of all hospitals seeking financing in the mid-1990's could not secure a loan solely on their own financial strength. Mortgage insurance fulfills a critical role by permitting some hospitals, under particular circumstances, to obtain capital (i.e., it removes the risks associated with default by guaranteeing payment to the lender). While many of the hospitals noted above were able to obtain private market mortgage insurance to help them obtain capital, almost 20 percent of the hospitals with questionable financial performance were not considered good risks by private bond insurers.

Over the last three decades two federal programs have been able to assist some of the less creditworthy hospitals turned away by private capital/insurance markets. The first program, established in the late 1960's is the U.S. Department of Housing and Urban Development's (HUD's) Hospital Mortgage Insurance Program (HMIP) and the second, established in the mid-1970's, is the U.S. Department of Agriculture's (USDA) Community Facilities Program (CFP). The contributions of each program while significant in their own right, have proved uneven (HMIP) and insufficient (CFP) in meeting the specific capital needs of rural hospitals.

Our findings indicate that of the more than two thousand rural hospitals in operation today, only a quarter have been able to take advantage of either of these two federal programs. In addition to exploring the potential role of these two federal programs for meeting rural hospital capital needs, this paper also discusses capital program efforts among the states. At this time, 22 states operate capital related programs for which rural hospitals may be eligible. Three states (California, Illinois and Minnesota) have two or more programs in operation. Although

many states do not appear to have the resources for establishing long-term major capital streams for their rural hospitals, a number have developed multiple programs. Some states such as Minnesota have taken specific steps to understand the capital needs of their rural hospitals to guide them in program development. Other states such as West Virginia have been able to invest some of the federal funding available under the Rural Hospital Flexibility Program to assess the capital needs of Critical Access Hospitals in their state.

Fifty-five percent of the state programs providing capital assistance to rural hospitals are completely supported by state funds while 27 percent are funded by a mixture of public and private sources and 18 percent are supported by a combination of state and federal funds. The majority (70%) of the programs provided capital through grants followed by direct loans (25%). One state offered a loan guarantee program.

As efforts continue to assess the nature and scope of rural hospital capital needs, this paper will be a critical backdrop from which to identify potential roles for existing federal programs and possible options for sharing existing state strategies and creating new initiatives. Much work is still needed to understand the nature and character of capital need in rural health care and, more importantly, the implications of failing to recognize or meet those capital needs for the health and well-being of rural populations.

### **Hospital Mortgage Insurance Program (HUD 242)**

The role of the HMIP is to provide mortgage insurance for eligible hospitals to help them obtain capital resources otherwise unavailable to them. At the time the HMIP was established, Congressional opinion held that there was a serious shortage of hospitals and the need for existing facilities to expand and renovate their operations. The express terms of the authorizing language states that the purpose of the program is to

*“...assist the provision of urgently needed hospitals for the care and treatment of persons who are acutely ill or who otherwise require medical care and related services of the kind customarily furnished only (or most effectively) by hospitals. Such assistance shall be provided regardless of the amount of public financial or other support a hospital may receive...”*

Since its creation the HMIP has been expected to be a self-supporting enterprise using the fees generated from its insurance product to maintain sufficient reserves to protect against loan defaults and to cover the management of its portfolio. With only a few exceptions, the program has met this charge maintaining a positive cash flow for the past twenty-five years and a loan default rate of under three percent. Over its thirty-three year history the HMIP has made billions of dollars available for hospital projects that otherwise may not have been able to garner the needed capital (i.e., assisting hospitals with low to non-investment grade bond ratings).

Unfortunately, even though this program targets hospitals specifically it has been very uneven in its support of rural hospital projects. Urban hospital projects represent the vast majority of program activity accounting for over four out of five endorsements and

approximately 97 percent of the program’s funding (i.e., urban hospital projects represent almost \$9 billion while rural hospital projects only about \$250 million of the program’s portfolio).

While some aspects of the unevenness between rural and urban hospital projects may be due to the large concentration of projects in only a few states (most notably downstate New York), there appear to be a wide variety of factors involved including public knowledge and understanding of the program and the need to dispel past concerns such as extremely long application time periods. Program staff have made significant progress in addressing a variety of issues that have risen over the past three decades. One of the most notable has been the expansion of the program to include Critical Access Hospitals (CAHs).

Although participation by CAHs has been slow to implement, the effort shows promise for assisting a number of rural hospitals that might otherwise appear too risky for traditional mortgage insurance agencies. Employing the same standards as the traditional HUD 242 program, this effort recalculates a hospital’s financial eligibility using the unique reimbursement features of the Flex Program (i.e., cost-based reimbursement).

As an insurance program the HMIP has specific fiduciary responsibilities that by and large make it more difficult for rural hospitals than urban facilities to be eligible for endorsement. The addition of experienced rural hospital staff as account executives has greatly improved the program’s capacity to understand and interpret the sometimes unique circumstances of rural hospitals. However, the presence of a number of structural issues makes it difficult for rural communities to take full advantage of the program in their efforts to stabilize their local health care infrastructure.

Our analyses identified the following recommendations for the HUD 242 Program that potentially could improve the availability of capital resources for rural hospitals under the program.

#### Regulatory Recommendations

1. Should HUD seek to further expand its portfolio, two regulatory options that could contribute significantly to assisting urgently needed hospital-based services in rural areas are including ambulatory care services as eligible projects to compliment current delivery system trends away from an inpatient service focus, and allowing hospital debt refinancing and the possible redirection of internal hospital capital for needed projects.
2. In the event that HUD decides to implement a revised need methodology for the HMIP, options should be considered to reduce barriers to participation and enhance the potential of endorsed projects to have a lasting positive impact on the participating hospital and the local rural population within its service area (e.g., inclusion of outcome-based criteria for the assessment of project compliance with program goals and their impact on the communities served by participating hospitals).

### Programmatic Recommendations

1. Continue and expand the HMIP portfolio of CAHs and use staff with first hand experience and appreciation of rural hospital operational and financial issues as account executives and sources of program technical assistance.
2. Where appropriate and consistent with statute and regulations, allow rural grant program funds (e.g., the Network Development and Outreach Grant Programs) to be used to cover the “up-front” costs of HMIP applications.
3. Conduct a federal program audit to identify program coordination options for better meeting rural hospital capital needs (e.g., existing loan and technical assistance programs as well as health care delivery and community development programs).
4. Explore the possibility of allowing revolving loan programs to sell mortgages on secondary markets (i.e., maximize availability of capital for rural hospitals).
5. Assess the potential for achieving administrative and program benefits through joint management efforts by HUD’s Office of Insured Healthcare Facilities and HHS’s Division of Facilities Loans.
6. Explore the development of a separate capital program (within the HMIP) for rural hospitals with promising hospital projects ineligible under existing federal criteria but that have a strong potential for meeting local health care priorities.
7. Explore the creation and incorporation of a quid pro quo linking capital access to projects that have demonstrated fiscal viability and the capacity for addressing key health care needs within the borrower’s project service area.

### Policy Recommendations

1. Identify options to minimize program and market-related financial risks in ways that do not create barriers to program participation or the achievement of program goals and objectives.
2. Minimize program participation barriers and maximize the achievement of program goals and objectives through regular performance reports to key stakeholders. Create a monitoring strategy that specifies program resource needs and potential risks that does not disadvantage the target group for the program.
3. Develop a resource development unit within the FORHP or establish a cooperative agreement to assist rural health care providers in identifying and understanding capital markets and access opportunities.



## **Community Facilities Program**

The USDA Community Facilities Program (CFP) makes loans, loan guarantees, and grants available to eligible projects providing essential services to rural towns or unincorporated areas with fewer than 20,000 persons. Essential community facility projects must contribute to the orderly development of the rural community (be a public improvement), comprise an essential public service (typically of the type provided by a local unit of government), have significant community support and not include private, commercial or business undertakings.

Loan and grant funds are allocated by state using a methodology that accounts for a state's rural population, level of unemployment and the number of households below the federal poverty level. Each state is provided a minimum allocation and given authority over loan projects under \$3 million. Loan projects over \$3 million or involving entities with an operating history shorter than five years require the approval of the program administrator and are handled at the National Rural Development Office. Approximately 80-90 percent of the available grant funds are allocated to the states with the remainder held in reserve by the National Office for special projects (distributed twice a year on a competitive project-by-project basis).

Even though the CFP does not specifically target hospitals, loans and loan guarantees for rural hospital projects make up a significant portion of the project portfolio. Loans to rural hospitals are, on average, larger than loans to any other entity supported by the program. Over the lifetime of the program approximately \$1.2 billion, or one quarter of all available funding under the CFP, has been used to support rural hospital projects. Since its inception in 1974, the CFP has provided 817 loans, loan guarantees and grants to 734 distinct rural hospital projects. Of these projects, 37 percent involved renovation activities, 31 percent expansion, and 15 percent were used to obtain new facilities. Less than one percent of project funds were used to refinance old debt.

Our analyses identified two regulatory and two programmatic recommendations that should enhance the potential of the Community Facilities Program for meeting rural hospital capital needs.

### Regulatory Recommendations

The Community Facilities Program is uniquely positioned to address the capital needs of rural hospitals and to support their role as an integral part of the local community.

1. Conduct a regulatory audit of the program standards to determine if rural hospital assistance can be specifically targeted through the CFP.
2. Determine if authorization exists to create a separate set of coordinated capital initiatives as a lender of last resort for rural health care facilities.

### Programmatic Recommendations

1. Consider increasing funding support for the program to enhance its ability to assist critical hospital operations in isolated rural areas and to develop a technical assistance capacity to coordinate health and economic development projects for rural areas.
  - (a) Assure program officials have access to individuals with health care development and operational experience when evaluating projects
  - (b) Increase USDA Rural Development field staff to enhance outreach and education efforts
2. Conduct an assessment to identify those rural hospitals unable to obtain funding from private markets or this program to identify program modifications that will better serve rural hospital capital and community needs.

Small rural hospitals have faced many threats to their survival since the termination of the Hill-Burton Program. At present rural hospital Medicare inpatient margins continue to be lower than that of their urban counterparts and the difference has widened over the last decade from less than a percentage point in 1992 to ten percentage points in 1999. Access to capital from private lenders has continued to tighten, particularly over the last three years and facilities continue to be buffeted by changes in operational and reimbursement requirements at the state and federal level. While some credit-rating agencies have reported that hospital margins have begun to level out, other sources point to the limitations of their data (i.e., those facilities seeking creditworthiness ratings for investors) and point to evidence suggesting that expenses continue to outpace revenues for most hospitals. While almost half of all states with rural hospitals have at least one capital program in place, only nine of the 27 programs specifically target rural hospitals. As state budget deficits continue to rise in the post 9/11 economy, there appears to be little hope of existing programs expanding to better meet the capital needs of rural hospitals and there is rising concern that the existing programs may begin to contract. Two key questions are:

- What will be the fate of those hospitals that cannot maintain the level of investment and modernization necessary to keep pace with advancements in medical practice?
- What will happen to the rural residents currently being served by these facilities?

## **PURPOSE**

The purpose of this paper is to:

- Identify federal and state sponsored programs that have assisted or could assist rural hospitals in meeting their capital needs;
- Assess if rural hospital borrowers have difficulty in meeting their capital needs under existing grant, loan and mortgage insurance programs; and
- Discuss potential options for improving access to capital for rural hospitals.

This document is based on information drawn from the following sources:

- Interviews with officials from the Federal Housing Administration (FHA) of the U. S. Department of Housing and Urban Development (HUD), the U.S. Department of Agriculture (USDA), the Health Resources and Services Administration (HRSA) of the U. S. Department of Health and Human Services, directors of State Offices of Rural Health, state finance authorities, lending agencies, hospital administrators, and representatives of state health care and hospital associations;
- Analyses of health care data including Medicare Cost Report Data; portfolio data on the Hospital Mortgage Insurance Program provided by HUD and on the Community Facilities Program provided by the USDA; and data on state sponsored programs;
- Federal and state agency documentation and promotional materials; and
- Reviews of applicable federal and state program laws, regulations, policy statements and reports.

## **BACKGROUND AND POLICY SIGNIFICANCE**

Rural hospital borrowers traditionally have had more difficulty gaining access to capital for development and modernization than their urban counterparts (Drabenstott, 1995). Rural communities have economies characterized by small businesses, fewer and smaller local sources of capital, less diversification of business and industry, and fewer ties to non-local economic activities. Even local banks, traditionally open to providing short-term loans to hospitals, are becoming less available as mergers continue between small rural community banks and larger banks not located in a rural area.

The first major attempt by the federal government to assist rural communities in obtaining capital resources for the improvement of access to hospital and medical care was launched in 1948 with the Hill-Burton Hospital Survey and Construction Act (Hill-Burton). While attempts to address disparities in access had begun sixteen years before with the work of

the Committee on the Cost of Medical Care (CCMC),<sup>1</sup> intervening events put a hold on most efforts. The combined effects of the “Great Depression” and the Second World War delayed actions such as those suggested by the CCMC and contributed significantly to a broadening of the disparity in access to health services. By 1944, with the war winding down and the nation’s economy gaining, the combined efforts of the American Hospital Association (AHA), the U.S. Public Health Service (PHS) and the Commission on Hospital Care and other stakeholders paved the way for the enactment of the Hill-Burton Hospital Survey and Construction Act of 1946 (Lave and Lave, 1974, Wilson and Neuhaser, 1985).

The purpose of the program was to reduce the perceived disparities in access to hospital and physician care through the construction of new facilities in areas with demonstrated need. Building new facilities was thought to be the key to encouraging more physicians to settle and practice in rural areas. Federal funds were provided to states to determine the need for new public and not-for-profit hospitals and in cases where there was a demonstrated need, to underwrite new construction. Participation in the program required that hospitals provide a “reasonable volume of free or reduced care” to “individuals unable to pay” and to make services generally available to all residents of their service area as a *quid pro quo* for the investment of federal dollars (Congressional Quarterly Almanac 1964).

By the program’s end in 1974, more than 10,700 projects had received assistance. One-third of the projects involved construction of new facilities, the remaining two-thirds were devoted to modernization (e.g., hospital beds, long-term care beds, outpatient facilities, rehabilitation facilities, public health centers and state health laboratories) (USDHHS, 1970; Lave and Lave, 1974). By 1986, the number of community hospital beds averaged 4.0 per 1,000 rural population and 4.1 per 1,000 urban population. Almost 75 percent of the projects targeted localities with populations under 50,000 persons and over one half of these were in localities with populations under 10,000 (OTA, 1990). At the program’s end, almost four billion dollars were distributed for state survey, planning and new facility construction and another nine billion dollars was leveraged for health care infrastructure from local and state matching funds (Starr, 1982). Although the basic premise underlying the program – a more equitable distribution of hospitals in rural areas would lead to a more equitable distribution of physicians in rural areas - did not materialize, many communities were given access to health care services previously only available at great distances (Wilson and Neuhauser, 1985; Rohrer, 1987).

By 1973, a large number of categorical grant programs, including the Hill-Burton Program, were nearing expiration. While the federal administration extended the programs for one year, Congress eventually sought consolidation and terminated many of them to make way for a broader health care planning initiative. The Health Planning and Resources Development Act (HPRDA) with its Health System Agencies formalized health planning through Certificate of Need Programs. While the HPRDA provided the infrastructure for assessing delivery system issues and promoting regionalization on a much larger scale than the Hill-Burton Program, it did not provide or facilitate the acquisition of capital financing for infrastructure maintenance and development.

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<sup>1</sup> In 1932 the CCMC recommended the extension of public health care services into rural areas, towns, and small cities (USDHEW 1970).

At that time, the two most significant federal programs available for providing or facilitating the acquisition of capital for rural health care needs were the U.S. Department of Housing and Urban Development's Hospital Mortgage Insurance Program (HMIP) and the U.S. Department of Agriculture's (USDA) Community Facilities Program (CFP). The CFP makes grants, loans and mortgage insurance available exclusively for rural areas but does not specifically target rural hospitals. The HMIP is designed specifically to facilitate hospital access to capital.

Analyses of Medicare Cost Report data reveal a significant aging of rural hospital infrastructure over the last forty years (Table 1). Rural hospitals are more likely to have buildings and equipment in use for more than twenty years compared to their urban counterparts and may have far less success in addressing their capital needs than urban facilities (i.e., lower average debt burden compared to urban hospitals).

Many rural hospitals have been able to partially address their capital needs through local means (e.g., short-term bridge loans from a local bank, charitable donations, tax credits and public fund-raising efforts).<sup>2</sup> While some hospitals continue to receive significant support from their communities, most can expect community support to decrease as rural economies continue a downturn started over a decade ago. Coupled with other events such as the advent of the Prospective Payment System with its dramatically reduced pass-throughs for capital expenses, access to capital has become more problematic for rural hospitals, particularly those with poorer financial performance. By the mid-1980's the single largest source of debt financing available to rural hospitals was bond sales. Historically, hospitals in good financial health with little debt and strong market potential have had little difficulty in obtaining loans from commercial lenders because the risk of default is very low. However, the availability of commercial capital to health care facilities has been contracting for all but those with the very highest of credit ratings since the late 1990's.

Some credit-rating agencies have suggested that the recent contraction of capital for the not-for-profit health care sector may be coming to a close. However, others remain cautious. Both Moody's and Standard & Poors anticipate credit rating downgrades to continue to significantly outnumber upgrades for at least several months (S&P, 2001b; Moody's, 2001).<sup>3</sup> In the first eight months of 2001, Standard and Poors reported that creditworthiness downgrades outnumbered upgrades by greater than five to one (S&P, 2001c). This trend not only reflects the current uncertainty about the not-for-profit health care sector but also a concern about future economic conditions. Investors have been trading health care bonds with interest rate spreads much wider than is being observed in other sectors. Bond insurers are underwriting fewer businesses than they were a few years ago and lenders have pulled back or dramatically raised their interest rates (S&P, 2001b).

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<sup>2</sup> A number of Critical Access Hospitals visited over the past two years by the Flex Program Tracking Project have relied heavily upon such funding sources.

<sup>3</sup> These observations are based on the financial, administrative and operational evaluation of hospitals that have retained Standard and Poors or Moody's for a current rating in their efforts to obtain capital..

**TABLE 1**  
**Hospital Facility Age and Debt Level by Location**

<b>Hospital Location</b>	<b>Buildings and Fixed Equipment Over 20 Years of Age</b>	<b>Ratio of Total Debt to Total Revenue</b>
Urban Counties	8.0%	50.4%
Rural Counties Adjacent to Urban Counties	12.6%	39.0%
Rural Counties not Adjacent to Urban Counties	15.9%	27.9%

\*The age of building and fixed equipment is estimated by dividing accumulated depreciation by the hospital's 1998 depreciation expense.

Source: 1998 Medicare Cost Reports

Rural hospitals having the most success in finding needed capital are likely to be municipally owned with the ability to use taxing authority to guarantee their bonds (Davis, 2001). Other hospitals lacking such support often need the addition of mortgage insurance to secure funding. However, obtaining mortgage insurance can be as difficult because of the lenders' need to minimize the risk of default.

Many hospitals facing tight capital markets have elected to enter into rental agreements to meet their equipment needs. While these agreements may comprise effective strategies for modernizing operations, they also can cost a hospital far more than would have been invested in an outright purchase and further erode their financial and market position (i.e., some agreements can have interest rates that rival or exceed those of commercial credit cards). Smaller hospitals that have used their cash reserves to maintain operations have fewer resources available to fund needed projects, making access to outside capital all the more critical for their survival (Office of Technology Assessment, 1990).

The ability to obtain capital for supporting hospital-related projects depends on three key factors: 1) the perceived ability of the borrower to honor the loan agreement; 2) the loan requirements of the lender to appropriately incorporate the fixed costs of the process and still meet profitability goals; and 3) the ability of the borrower to obtain mortgage insurance to offset potential risks to the lender.

In the pages that follow, we will discuss two federal programs (i.e., HMIP and the CFP) that have contributed to meeting rural hospital capital needs. Our findings indicate that of the more than 2,000 rural hospitals in operation today, only a quarter have been able to take advantage of either program to obtain capital. We also consider the range of state supported capital programs that are available for helping rural hospitals meet their capital needs. State programs are available in less than half of the states and rely heavily upon grant awards as their means of providing capital assistance. Rural hospitals operating in states without a capital program have no other public alternative and the majority of those that do have a state program often have only grant funds to meet their needs. Grant funds seldom are large enough to meet the critical capital needs of hospitals that loans readily address.

## **THE HUD HOSPITAL MORTGAGE INSURANCE PROGRAM**

### **Mortgage Insurance and its Role in Capital Acquisition**

The statutory responsibility for the Hospital Mortgage Insurance Program (HMIP) lies with the FHA, specifically the Office of Insured Health Care Facilities, as part of the Department of Housing and Urban Development's (HUD's) General Insurance Fund and was intended to replace the Hill-Burton program (Taylor, 2000).<sup>4</sup> Management of the program is the joint responsibility of FHA's Office of Insured Healthcare Facilities (OIHF) and the Division of Facilities Loans located within HHS.

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<sup>4</sup> The HMIP is required to be self-sustaining. This is not the case for the General Insurance Fund which receives Legislative appropriations when necessary.

The HMIP was established in 1968 with the addition of Section 242 to the National Housing Act (12 U.S.C. 1715z-7) and is commonly referred to as the HUD Section 242 Program. At the time of this Congressional amendment to the National Housing Act, the House Committee on Banking and Currency<sup>5</sup> had cited a serious shortage of hospitals and the need for existing facilities to expand and renovate their operations (USDHHS, 1970). The explicit purpose of the HMIP was crafted with these needs in mind and to target meeting the capital needs of “urgently needed” hospitals in particular. “Urgently needed” hospitals include those that play a significant part in meeting the health care needs of the local population, including rural facilities. The implication is that these hospitals are needed but also are having difficulty in finding any lender to back needed projects to help them continue in their community role.

Although local lenders and banks may be able to provide some of the capital that a hospital needs to renovate, modernize or construct new facilities they rarely have the means to support major projects. Major projects usually require greater amounts of capital and longer financing periods than the local market can support through community-based savings and investments. Larger, more financially stable hospitals have been successful in securing loans from private market lenders. This has not been the case for many rural hospitals because of their smaller size and lower creditworthiness. Lower levels of creditworthiness lead to lower hospital ratings by lenders and a higher cost or less availability of capital.

According to the Health Care Financing Study Group,<sup>6</sup> about 60 percent of all hospitals seeking financing in the mid 1990’s could not secure a loan solely on their own financial strength. Mortgage insurance removes the risk of default by guaranteeing that the money will be available to pay the bondholders. In effect, it is the lender and not the hospital that is insured against financial losses if mortgage payments are not made. While many of these hospitals were able to obtain private market mortgage insurance to help them get their loan, almost one-fifth of the hospitals with questionable financial performance were considered too risky for private bond insurers (General Accounting Office, 1996a).

The key difference between the HMIP and private market mortgage insurers is that the HUD 242 Program can and does insure mortgages for hospitals that have lower bond ratings than considered acceptable in the private sector.<sup>7</sup> Providing insurance to hospitals with low to non-investment grade bond ratings compared to the substantially higher ratings required by private insurers has opened an avenue for mortgage insurance for hospitals previously excluded from the private market. It also has resulted in reduced interest rates for some facilities that might still qualify for private insurance. For example, one hospital, albeit an urban facility, that was at a cut point in terms of mortgage insurance criteria with a BB+ rating was able to save four percentage

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<sup>5</sup> Currently the Committee on Banking and Financial Services.

<sup>6</sup> 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.

<sup>7</sup> The HUD 242 Program also will provide refinancing for existing debt burden up to 80 percent of the total mortgage amount. In addition, the FHA has authority under existing legislation to use the 223f program for refinancing multi-family housing debt. Attempts are currently underway to develop regulations for expanding this program to include hospitals.



points with HUD compared to the private market. In short, HUD 242 can provide mortgage insurance to hospitals that do not qualify, or must pay greater interest to qualify, for private sector mortgage insurance making them better risks to private market lenders. Payments to the lender are guaranteed with the backing of the Federal Government.

### **The Role of the Hospital Mortgage Insurance Program**

Since its creation the HMIP has been expected to be a self-supporting operation that provides for the salaries of its staff and generates sufficient funds in reserve to cover any defaults and any related expenses for managing its insurance portfolio. There have been occasions where the FHA was allocated funds through Congress (a credit subsidy through the Office of Management and Budget) to cover claims amounts exceeding its reserves.<sup>8</sup> The most recent assessment of the financial health of the HMIP, conducted in 1995, concluded that the program's overall financial track record has contributed to a net positive cash flow over the past twenty-five years.<sup>9</sup> Since the portfolio was opened in 1969, three hundred and ten hospital projects have been underwritten for a total of almost \$9 billion. The overall default rate over the history of the program has been 2.5 percent and FHA officials credit the very respectable rate to a thorough evaluation and application process as well as vigorous portfolio and asset management (Miller, 2001).

Although credited with limiting claims, the process also appears to have been responsible for long approval times, a strong concern of hospitals, state healthcare associations and Congress. In its assessment of the financial performance of the HMIP, the GAO found that the average processing time was 18 months from first submission of an application to final approval. Although interviews suggested that some of the delay was due to hospitals not responding to questions in a timely manner, the most significant factor was the number of offices involved in the application review (General Accounting Office, 1996a). In response, the FHA and HHS initiated efforts to streamline the process including using a team approach to analyze applications and involving FHA's staff earlier in the process.

The result of these efforts is outlined in Appendix A. The process begins with a hospital contacting either HHS or HUD and the issuance of a "Customer Self-Determination Pre-Test" for guiding potential applicants to reach their own preliminary assessments about their potential for meeting HMIP minimum eligibility criteria (Appendix B). Hospitals meeting minimum requirements and willing to comply with the basic terms and conditions of the program are encouraged to contact FHA staff in the Office of Insured Health Care Facilities located at HUD's Central Office in Washington, DC. In addition to the criteria specified in the pre-test guide, mortgages may not exceed 25 years in length, applicants must submit a one-time application fee of 0.8 percent of the total loan amount, and mortgagees must agree to pay a fixed annual

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<sup>8</sup> Over the past decade there have been a number of evaluations and hearings involving the GAO and OIG concerning the validity of HUD's risk forecasting methodologies (i.e., ability to forecast potential claims and maintain sufficient reserves to offset the expected claims).

<sup>9</sup> Between 1969 and 1994, the FHA collected \$370 million in premiums and fees and paid \$200 million in insurance claims (\$147 million between 1989 – 1991) and \$13 million in salaries and administrative expenses (\$64 million in claim payments was recovered from mortgage payments and the sale of the mortgages or properties).

premium of 0.5 percent of the remaining balance of the mortgage at the beginning of each year following the endorsement of the mortgage.

An account executive, which may be a staff person from either HHS or HUD, is assigned to the hospital and remains the account executive throughout the application and review process and for the term of the mortgage loan, if approved. This account executive heads a client service team comprised of personnel from both HHS and HUD. The client service team is responsible for the collection and verification of information related to the project and its feasibility. While HUD has the statutory responsibility for making the decision (specifically the FHA Commissioner), HHS personnel are very involved throughout the process as members of the client service team (e.g., providing expertise in health care administration, financial analysis, accounting, architecture and engineering) and as members of the Program Management Group providing final recommendations to the Director of the Office of Insured Healthcare Facilities.

Following a successful preliminary review, the client service team schedules a pre-application meeting on-site and the applicant provides a formal presentation with all relevant parties present (e.g., attorneys, architects, and financial consultants). A flexible evaluation process is employed to assess a borrower's eligibility for mortgage insurance. Private mortgage insurers often approach potential mortgage insurance clients on a case-by-case basis but this flexibility usually is reserved for facilities with much higher bond ratings than those assisted by the HMIP. FHA employs a range of experts and encourages them to be as creative as possible given the statutory and regulatory requirements governing the program's operation (Miller, 2001). The ability of the HMIP to work with borrowers that might otherwise not qualify for commercial lending is supported by the use of a multi-tiered evaluation process that adjusts for varying degrees of creditworthiness (Appendix C).

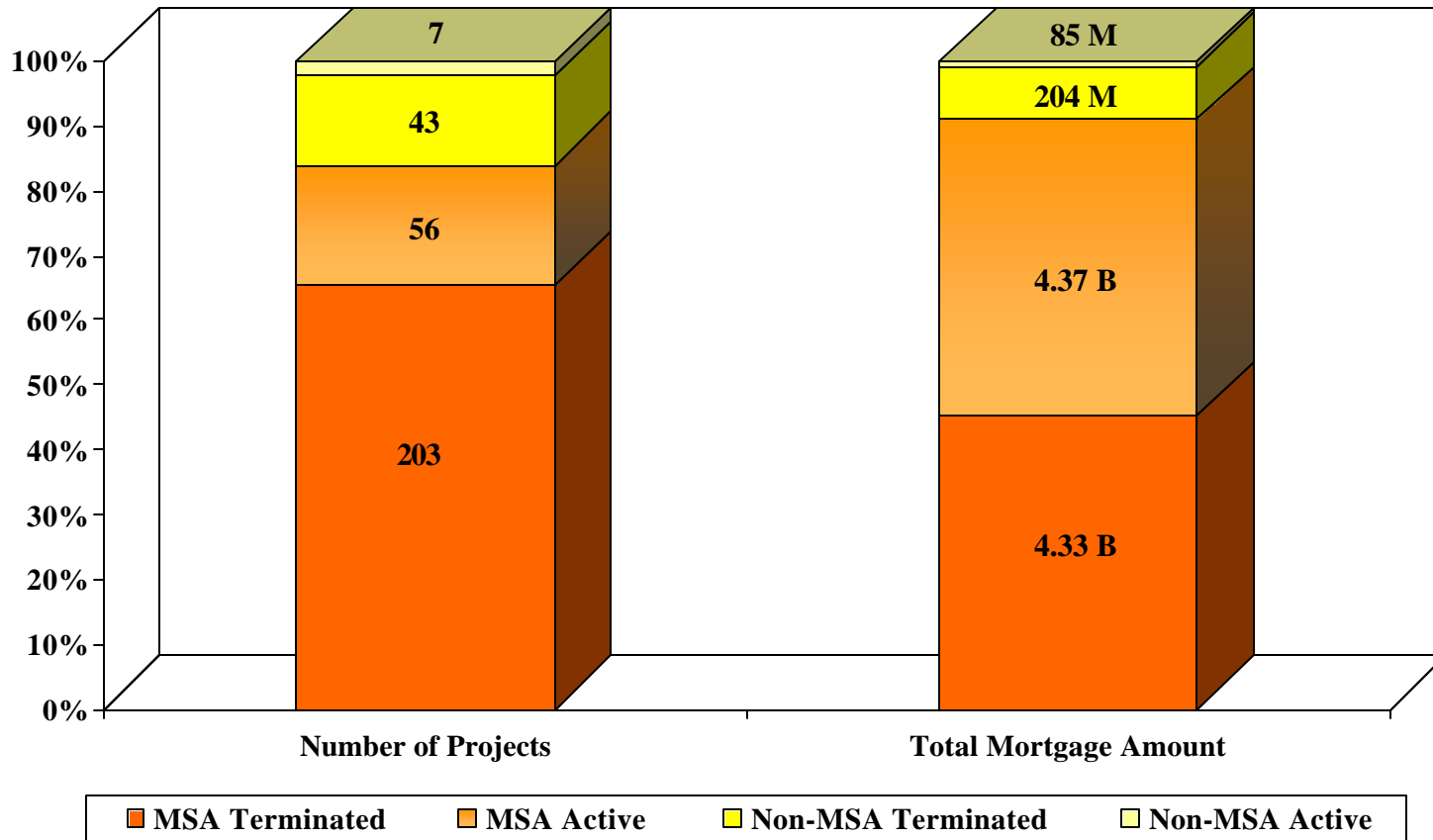
### **Meeting Rural Capital Needs**

Over its 33-year history the HUD 242 Program has provided far more support for urban hospital projects than rural projects in terms of the number of projects supported (84%) and the total amount of mortgages insured (97%) (Figure 1). Analysis of the hospital projects endorsed over the program's lifetime reveals that while rural hospitals were included in the initial underwriting efforts, endorsement of urban projects far outpaced those for rural projects (Figure 2). These trends also were mirrored in increases over time in the size of insured mortgages. Urban hospitals demonstrated a steady increase in funding totals per project; however, the funding levels for rural projects remained static over the entire period covered by the data (Figure 3).

Hospital characteristics were compared for all urban and all rural hospitals receiving support from the HMIP as well as for hospitals that are current participants versus those that have completed their mortgage insurance agreements (Table 2). Comparisons between hospitals that have been terminated from the portfolio versus those that are still active were made in an attempt to address the extended time period covered by the portfolio. Not surprisingly, urban hospitals supported by the program were significantly larger than their rural counterparts. Comparisons between active and terminated projects revealed that urban hospital participant size has grown

**FIGURE 1**

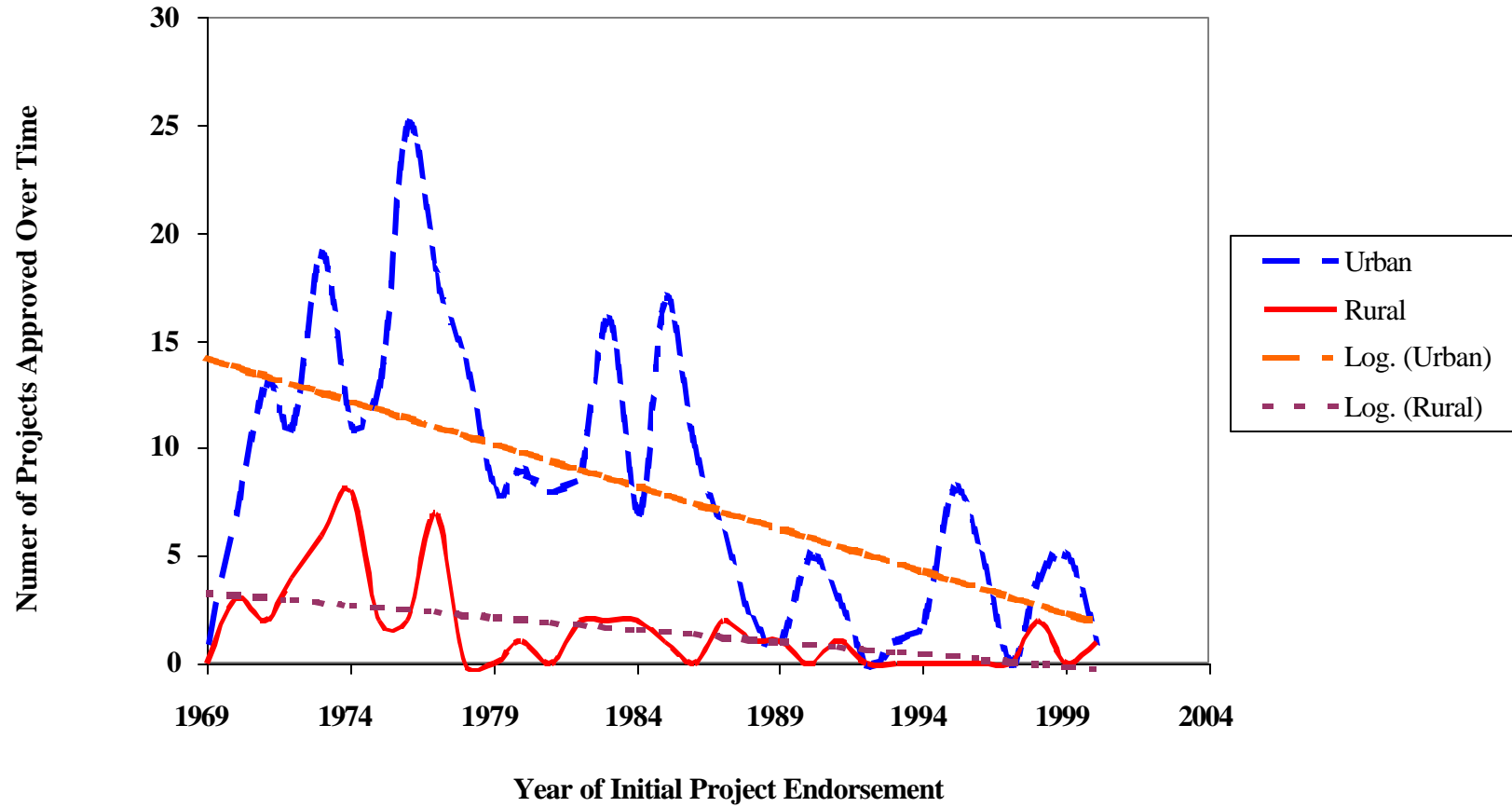
**HUD 242 Projects and Insured Mortgages by MSA/Non-MSA Location**



Source: HMIP Portfolio Data as of July 30, 2001

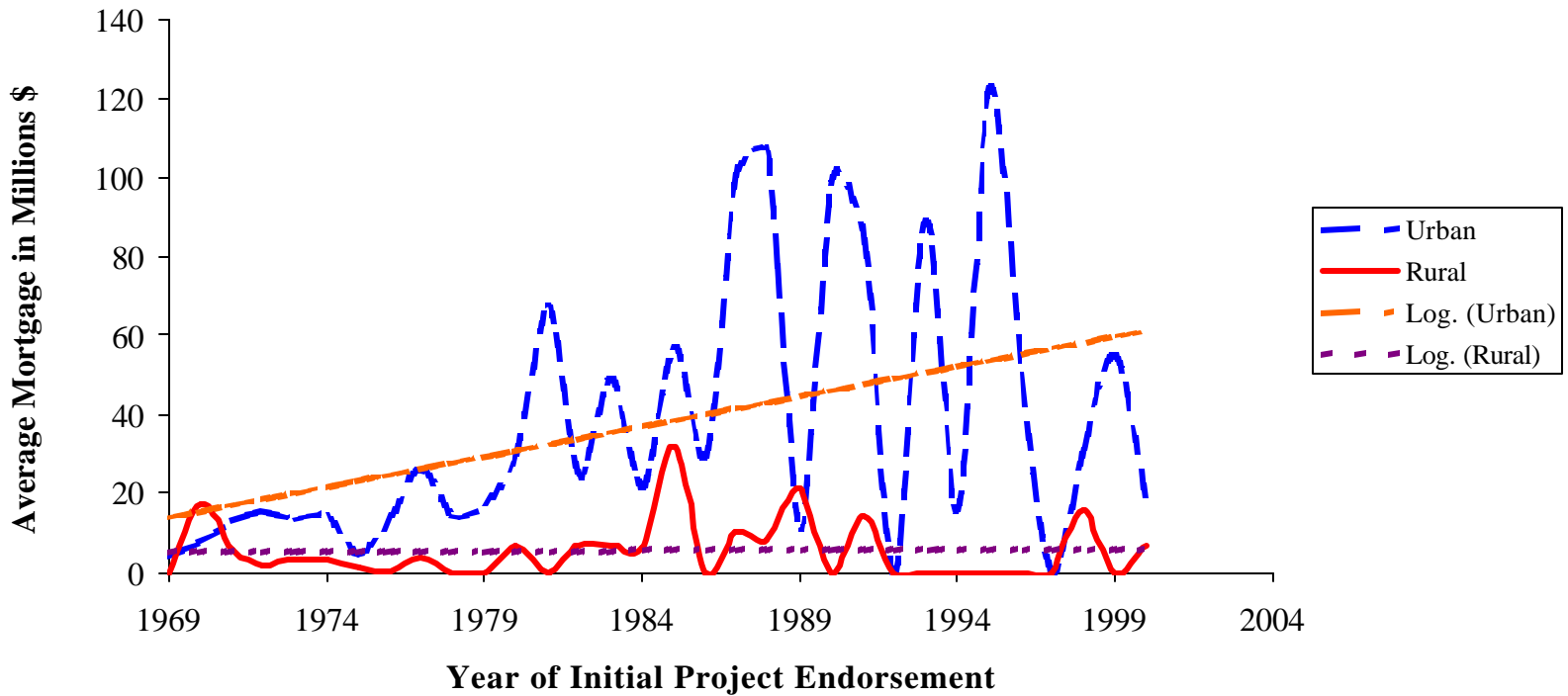
FIGURE 2

Number of HUD 242 Projects by Year of Endorsement  
1968 - 2001



Source: HMIP Portfolio Data as of July 30, 2001

**FIGURE 3**  
**HUD 242 Average Project Size by Year of Endorsement**  
**1968 – 2001**



Source: HMIP Portfolio Data as of July 30, 2001

**TABLE 2**  
**Characteristics of HUD 242 Rural and Urban Projects**

	<b>All Projects 1968 - 2001</b>		<b>Active 1976 – 2001</b>		<b>Terminated 1968 - 1998</b>	
	<b>Urban (n=259)</b>	<b>Rural (n=50)</b>	<b>Urban (n=56)</b>	<b>Rural (n=7)</b>	<b>Urban (n=203)</b>	<b>Rural (n=42)</b>
Hospital Size (Beds)	323	108	490	75	277	113
Mortgage in Millions \$	33.5	5.8	77.7	12.1	21.3	4.8
Interest Rate	8.5%	8.5%	7.2%	7.8%	8.8%	8.6%
Unpaid Balance as a Percent of Mortgage	--	--	--	--	69.0%	63.0%

Source: HMIP Portfolio Data as of July 30, 2001.

while rural hospital size has shrunk.<sup>10</sup> Differences in the level of mortgages between urban and rural projects suggest that urban projects may be more likely to involve expansions while rural projects may be more devoted to maintaining the status quo. Whether this is a reflection of different market dynamics, strategic predilections of hospital administrators or programmatic influence and awareness is unclear.

Although there were large differences in bed and mortgage size between rural and urban hospital projects, the only notable difference in insurance activity was that rural hospitals were less likely to default on their mortgage commitments than urban hospitals (Table 3). Urban hospitals were almost twice as active in the assessment of default claims as rural projects (9% versus 4.7%).<sup>11</sup> The differences may reflect a systematic influence in the operational characteristics of the process (e.g., existing standards may be inappropriate for rural hospitals because of their operating environments).

The increase in mortgage sizes in active compared to terminated insurance contracts may be a result of the disproportionate allocation of mortgage insurance in New York State and New York City in particular. The northeast region of the United States is well represented in the portfolio accounting for over half of all projects and almost 60 percent of all urban projects. New York State hospitals account for over one-third of all urban hospitals and approximately one-sixth of all rural hospitals insured by the program. Although urban hospitals are significantly over represented in the Northeast region of the U.S., rural hospitals are relatively equally distributed (Figure 4).

These statistics describe rural hospital participation in the HUD 242 program relative to urban hospitals by region but do not address how much the program may have met the needs of rural hospitals. There are no available reports that specifically assess the program's impact on meeting the capital needs of hospitals in general, or specifically rural hospitals.<sup>12</sup> There also are no public reports assessing the performance of the HMIP in meeting the capital needs of hospitals. Two major efforts to assess the HMIP were completed during the past decade and neither addressed how well capital needs were being met. The first report focused on the program's organizational structure (Office of Management and Planning, 1992) while the second assessed its financial performance (Government Accounting Office, 1996a).

The GAO report concluded that, while the program's functions and responsibilities fell within the purview of HUD's general mission, it was difficult to assess performance because program accomplishments were not routinely measured. At the time the FHA had not been

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<sup>10</sup> This may be an artifact of a small sample size for active rural hospital projects compared to active urban hospital projects.

<sup>11</sup> Both rural hospitals were located in New York, and under 50 beds while the seventeen urban hospitals averaged 190 beds and had dramatically higher mortgages (i.e., \$3.2 and \$6.7 million for the rural hospitals and a range of \$2.4 to \$41 million for the urban hospitals).

<sup>12</sup> This contrasts with the repeated assessments and Congressional hearings about the performance of other FHA programs (e.g., the single family, multi-family housing, multi-unit rental and rural housing programs).

**TABLE 3**  
**HUD 242 Termination Activity**  
**Characteristics of Urban and Rural Projects**  
**(1969 – 1998)**

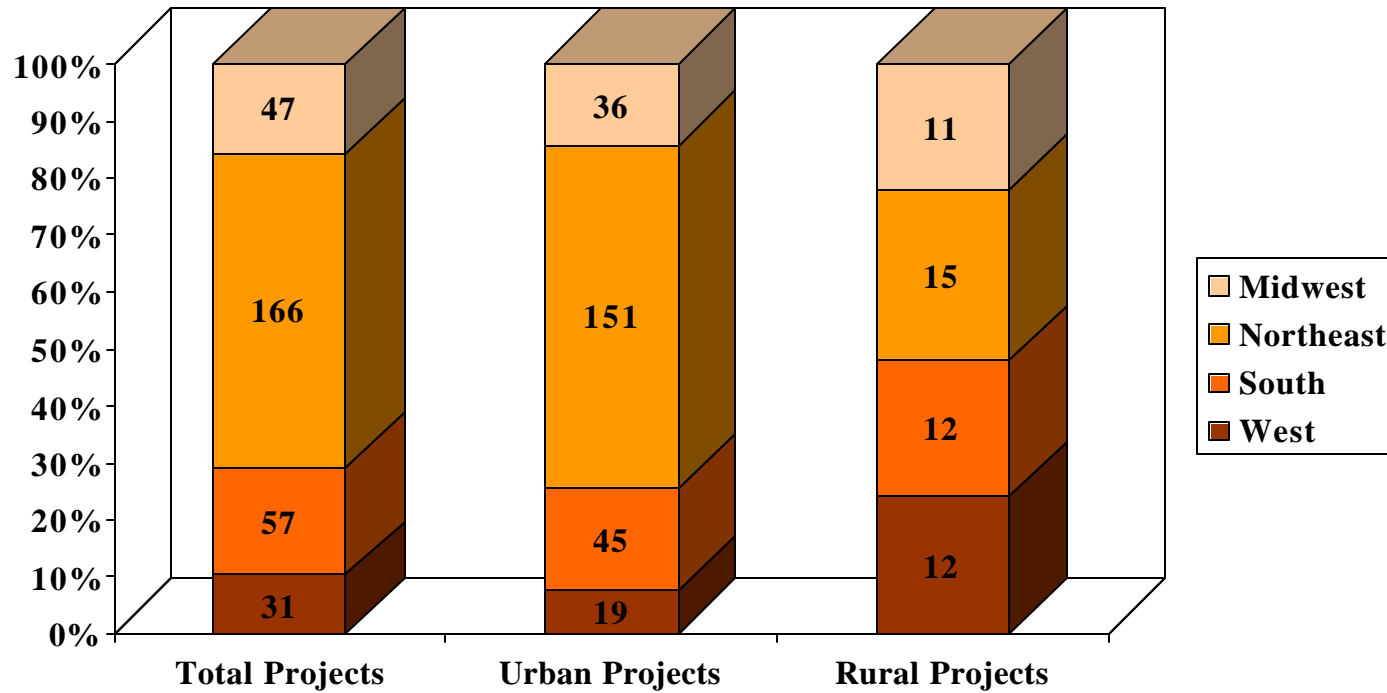
	<b>Urban (n=203)</b>	<b>Rural (n=43)</b>
Mortgage Prepaid Prior to Maturity	84.7%	90.7%
Correction – project endorsed in error	0.5%	0.0%
Maturity – mortgage matures	1.5%	2.3%
Assignment – claim is paid by HUD	8.9%	4.7%
Acquired – through foreclosure	0.5%	0.0%
Voluntary termination of insurance	3.9%	2.3%

Source: HMIP Portfolio Data as of July 30, 2001



**FIGURE 4**

**HUD 242 Portfolio by Census Region  
1968 – 2001**



Source: HMIP Portfolio Data as of July 30, 2001

required to use performance measurement methods to assess its effectiveness in meeting program goals and statutory intent (i.e., it was not in violation of existing policy or rules). It also warned of the portfolio's vulnerability to health care market trends, especially state trends since many contracts were in New York.

Following the report's recommendations to diversify its insurance portfolio in the mid-1990's<sup>13</sup>, HUD began taking action to diversify by marketing the program nationally to attract hospitals from other states. Specific issues surrounding the difficulty in including hospitals from other areas of the country were related to "disinterest because of the program's high premiums, lengthy application process and general lack of program awareness" (Government Accounting Office, 1996a, page 10).

According to FHA officials, efforts to reduce the turnaround time between submission of a complete application and endorsement have resulted in a four-fold decrease (i.e., from between 12 to 18 months down to four months). Unfortunately, they have not been able to identify how to reduce the period of time it usually takes to prepare the complete application which can take between six and nine months. Some of the most time consuming aspects of the application process include the development of complete architectural plans, engineering specifications, and financial feasibility assessments (Ervin, 2001). The financial investment in this process can also be significant and can cost more than \$200,000 for the hospital and lender (e.g., travel expenses, time costs of the financial feasibility study, architectural fees). Most of these costs (excluding the HUD application fees at .8 percent of the total loan amount) can be rolled into the mortgage amount if the mortgage is fully endorsed. Unless an applicant has certain access to funds to cover such costs it can be very difficult to approve the application because of the inherent risks of such a project. For example, the uncertainty could make it difficult to find contractors willing to defer payment for long periods of time or to find a lender willing to cover contractor costs without significant demonstration of the facility's ability to repay.

In addition to assessing the nature, cost and feasibility of a project, borrowers must demonstrate that a project is needed and appropriate given local and regional health care system characteristics. Prior to the sunset of the Health Planning and Resource Development Act in the 1980's and the repeal of many state Certificate of Need (CON) Programs, state CON approval was accepted as proof of a project's need. The elimination of a public process for assessing projects according to a set of standards (e.g., access, quality and cost) in all but twenty-four states made it necessary for the HUD program to require an alternative assessment for non-CON state hospital projects. Many hospitals in non-CON states have been unable to meet the requirement because the entity responsible for such activities in their state either is unable to conduct or to underwrite any assessment of need activities (e.g., state procurement laws blocking the use of state funds to pay a non-state entity for performing the needs assessment). Hospitals in the twenty-four CON states continue to use their state's approval of their CON application to demonstrate project need. Legislation has been proposed (S.1216) that would eliminate the program's use of a CON application or its equivalent to demonstrate need and would require

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<sup>13</sup> At present, 83 percent of all outstanding mortgages are located in New York State making the portfolio particularly vulnerable to health care market trends specific to New York (e.g., managed care, Medicaid eligibility changes, rate setting policies).

HUD to propose a more timely, appropriate and less expensive assessment process (Miller, 2001).

In addition to the technical and organizational efforts, the Office of Insured Health Care Facilities has launched a campaign to educate hospital administrators and boards about the HMIP. This effort has included the use of brochures and articles in trade magazines, web site links and staffing public events to increase the visibility of the program but has not had the impact that was anticipated. Since the mid-1990's, there were a total of twenty-six new hospital projects of which only three were rural (all non-New York facilities). Of the remaining new projects, 87 percent were from New York City.

### **Mortgage Insurance for Critical Access Hospitals**

In the late 1990's, the HMIP began to explore options for further diversifying its loan portfolio to include smaller rural hospitals. This effort began to take shape with the launching of the Medicare Rural Hospital Flexibility Program. Small rural hospitals have been at a distinct disadvantage in using the services of private market mortgage insurers. Most large mortgage insurers are located in large metropolitan areas and are accustomed to working on substantial projects costing tens and hundreds of millions of dollars. The fixed costs associated with closing a mortgage insurance contract make mortgage insurers aware of what it takes to make a project cost-effective.

In some instances the size of a loan request can bar access to capital even for hospitals in good financial condition because the request is too small to make the effort worthwhile to a lender. The majority of private lenders set the loan amount floor at approximately \$5 million (Ervin, 2001). Although programs like the HMIP are able to endorse smaller projects, a loan guarantee can still involve fixed costs of up to \$100,000.<sup>14</sup> With the program's requirement for payment of application fees prior to endorsement, these fixed costs can become significant for some hospitals seeking assistance from the HUD Program, especially those in dire financial condition. A portion of these hospitals may now find that they are more likely to obtain capital because of their new status as a Critical Access Hospital (CAH) under the Medicare Rural Hospital Flexibility Program.

The provision of CAH mortgage insurance has the potential for helping facilities previously unable to qualify because they are permitted to use cost-based, rather than the usual PPS-based, projections to determine their financial profiles. A CAH applying for mortgage insurance under the HUD 242 program must meet the standard program qualifying criteria (e.g., operating margin of 0.0 and a debt ratio of equal to or greater than 1.25 for the past three years of operation). If a CAH cannot qualify under PPS-based financial information it has the option to use cost-based reimbursement assumptions to recalculate its financial strength.

Additional flexibility is available to prospective CAH borrowers to meet the "project need" requirement. While CAHs operating in states with CON programs continue to submit their approved applications as a demonstration of need, hospitals in states without CON

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<sup>14</sup> Costs average between \$50,000 - \$75,000 for legal fees and approximately \$25,000 for consulting fees to get mortgage insurance.

programs are deemed to have needed projects by virtue of their state's designation and certification as a CAH by the Center for Medicaid and Medicare Services.

Because of the added flexibility afforded to CAHs a larger number of small rural hospitals will be eligible for mortgage insurance than previously. In addition to the significant reductions in processing time from completed application to loan endorsement achieved for non-CAH loan applications, FHA staff have reduced the goal for CAH applications down to two months. Delays that may result from either hospital or lender issues are expected to diminish as HMIP staff continue to work closely with key parties through their Client Service Team. By working in tandem with the Medicare Rural Hospital Flexibility Program, FHA program staff will find additional opportunities for educating hospitals about the HMIP and providing needed technical assistance.<sup>15</sup>

HMIP account executives have made themselves available to provide information on-site and to discuss the benefits and opportunities of program participation. As CAHs and potential CAHs begin to receive more information about the HMIP from their State Offices of Rural Health and Healthcare Associations, program staff expect interest to grow.

## **Recommendations**

The following recommendations are divided into three categories: regulatory, programmatic, and general policy recommendations. The recommendations specifically focus on the capital needs of rural health care providers traditionally excluded from private loan/insurance markets through changes in existing regulation and program design. Recommendations also are presented to identify options for the implementation of existing and future capital-oriented programs.

### Regulatory Recommendations

1. Should HUD continue its efforts to expand its portfolio, there are at least two approaches available through regulatory amendment.
  - (a) Expand the scope of eligible projects under the HMIP to include hospital-based ambulatory care services.
    - Encourages administrators and board members/trustees to consider reorganizing in ways consistent with current health care sector trends (i.e., shift from inpatient to outpatient focus).
    - Provides opportunities for improved returns on investment and a corresponding decrease in the risk of mortgage defaults.
    - Promotes greater delivery system rationalization (e.g., facilitates reduction of excess beds, integration of emerging technologies into rural practice patterns)

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<sup>15</sup> HUD has hired specific staff with rural hospital experience to assist in the CAH 242 process.

and the potential economies available through interorganizational arrangements).

- (b) Increase the availability of funds to endorse debt refinancing for rural hospitals.
  - Addresses existing hospital debt and could free-up capital resources to support projects too small for the HMIP.
  - Makes additional support available to hospitals in the HUD 242 portfolio potentially enhancing their financial stability and reducing likelihood of default on mortgage obligations.
2. In the event that a revised need methodology is required by the HMIP for hospitals operating in non-CON states,
  - (a) Provide explicit need criteria within a design that minimizes the need for the collection/analysis of complicated and/or expensive data to enhance program participation and accountability.
  - (b) Apply a standardized criteria of need based on clearly defined program goals and objectives that are applicable to all participating hospitals regardless of the status of their state’s CON legislation.
  - (c) Consider inclusion of need and eligibility criteria that addresses the financial risk to public funds and the risks to public health and welfare (i.e., assessment should include the potential for default on obligations as well as potential market failure and local impact should capital not be made available).
3. Conduct a regulatory audit of the provisions for applying for hospital mortgage insurance to determine its applicability for rural hospitals. The program appears to be designed primarily to handle the operational and financial circumstances of large urban hospitals.

#### Programmatic Recommendations

1. Continue and expand the HMIP portfolio of CAHs and use staff with first hand experience and appreciation of rural hospital operational and financial issues as account executives and sources of program technical assistance.
2. Where appropriate and consistent with statute and regulations, allow rural grant program funds (e.g., the Network Development and Outreach Grant Programs) to be used to cover the “up-front” costs of HMIP applications.

3. Conduct a federal program audit to identify options for program coordination to meet rural hospital capital needs.
  - (a) Assess potential of existing loan guarantee and technical assistance programs for helping rural hospitals develop and implement promising projects unable to receive backing due to insurance market issues.
  - (b) Explore avenues for coordinating health-focused programs with programs targeting small community enterprise development.
  - (c) Coordinate revolving loan programs with community development corporations that have funds capitalized by grants and/or long-term low interest federal loans.
4. Explore the possibility of allowing existing revolving loan programs to sell mortgages on secondary markets to maximize the availability of capital resources for rural hospitals.
5. Assess the potential for achieving administrative and program benefits through joint management efforts by HUD's Office of Insured Healthcare Facilities and HHS's Division of Facilities Loans.
6. Explore the development of a separate capital program (within the HMIP) for rural hospitals with promising hospital projects ineligible under existing federal criteria but that have a strong potential for meeting local health care priorities.
7. Explore the creation and incorporation of a quid pro quo linking capital access to projects that have demonstrated fiscal viability and the capacity for addressing key health care needs within the borrower's project service area (i.e., require identification of key health issues, development of appropriate action plans and a means to evaluate the success of meeting identified need).

#### Policy Recommendations

1. Any expansion of the availability of capital for rural hospitals must include provisions for minimizing the risk of program bankruptcy (i.e., in the case of the HUD 242, program failure due to insurmountable mortgage defaults).

There has been some concern about the degree to which the HUD 242 program has assisted hospitals with urgent needs. An important issue is whether the scope of eligible projects should be expanded to better meet the growing health care needs of rural communities (i.e., ambulatory care projects).

Future efforts to improve access to capital for rural hospitals will face a variety of policy-related issues including:

- How should future capital initiatives target their assistance and what types and levels of risk should be considered appropriate (i.e., program, market, and consumer-related risks)?
  - To what degree should the availability of capital programs for rural hospitals be based solely upon their “creditworthiness” and the financial feasibility of the proposed project?
  - Should eligibility and endorsement for capital assistance include the potential non-financial benefits or costs involved in supporting rural hospital projects (e.g., access to quality services or the loss of access because of a failed project or failure to obtain capital underwriting)?
  - To what degree can program design provide protection from the barriers to participation that occurred with assessment of need criteria (i.e., non-CON states being unable to assist their hospitals in meeting program criteria)?
2. Possible options for minimizing the barriers to program participation and the achievement of program goals and objectives include:
- (a) Provide timely and scheduled dissemination of program performance data to key policy and program stakeholders for assessing the degree to which the program is meeting its statutory intent and addressing the needs of the rural hospital sector.
  - (b) Program design should provide confidence that resource needs will not exceed expectations/projections and those clients most in need are not inadvertently disadvantaged (i.e., strike a balance between the program resource requirements and policy resource priorities without undue risk to closing the doors of hospitals critical for meeting community health care needs).
    - Establish eligibility criteria to channel program dollars, but avoid spreading resources so thin that participants cannot achieve the proposed outcome for the client as well as the impact on the population being served.
    - Set limits/caps on the amount of funding that can be provided or on the amount of risk that can be safely carried, but monitor the proposed limits/caps to insure they do not create barriers for those hospitals that need assistance the most.
    - Develop evaluation measures for the timely and effective measurement of project outcomes and their compatibility with project objectives and program goals.

3. Create a resource development unit within the FORHP or establish a cooperative agreement to assist rural health care providers in identifying and understanding capital markets and access opportunities.
  - (a) Assist the dissemination of information about sources of capital for construction, modernization and renovation.
  - (b) Synthesize the Federal Catalogue of Domestic Assistance into a user-friendly format for hospital and other health care administrators.
  - (c) Sponsor educational and technical assistance sessions to maximize the awareness of, and ability to use, existing programs effectively (e.g., strategic planning and financial modeling).

### **THE USDA’S COMMUNITY FACILITIES PROGRAM**

The Community Facilities Program was established as a loan program by the Consolidated Farm and Rural Development Act of 1972 (P.L. 92-419, 7 U.S.C. Sec. 1926). The program obligated its first direct loan funds in 1974. Guaranteed loans were added in 1990 and grants in 1997. The guaranteed loan<sup>16</sup> program was added to make capital more widely accessible. Direct loans are highly subsidized by the USDA and more costly to the agency and ultimately the taxpayer (Parker, 2001).

The program is not limited to health care or hospitals but loans for rural hospital projects make up a significant portion of the portfolio and are significantly larger than the average loan in the program. Over the program’s lifetime it has obligated close to a quarter of its total funds – approximately \$1.2 billion – for rural hospital projects. Since its inception in 1974, the Community Facilities Program has made 817 loans, loan guarantees and grants to 734 distinct rural hospital projects.<sup>17</sup>

#### **Goals**

The objective of the program is to “construct, enlarge, extend, or otherwise improve community facilities providing essential services to rural residents” (Catalog of Federal Domestic Assistance, no date). This program is not exclusive to rural hospitals or rural health care infrastructure. It applies to essential community facilities which include but are not limited to day care, hospitals, schools, clinics, roads, and fire halls.

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<sup>16</sup> Guaranteed loan: a third party – in this case the USDA – sells a loan guarantee to the lender, which protects the lender in case of default by the borrower. The seller of the loan guarantee (the USDA) assumes the borrower’s obligations in case of default.

<sup>17</sup> A project is defined as one or more loans, loan guarantees, and grants to the same borrower (applicant) in one year. A number of hospitals/borrowers have received funds in multiple years.



## Eligibility

There are two sets of eligibility criteria. The first applies to the applicant, the second to the service area. First, the applicant has to:

1. be operated on a not-for-profit basis,<sup>18</sup>
2. have the legal authority for constructing, operating, and maintaining the proposed facility, and
3. be unable to finance the project through private capital markets at reasonable rates and terms (Catalog of Federal Domestic Assistance, no date).

Second, the project has to be in a rural area. The rural definition used by the Community Facilities Program has two parts: the project has to be in a town or unincorporated area of less than 20,000 population (based on the last Decennial Census) and it must primarily serve rural residents.

The inability to borrow elsewhere is determined using a cash flow analysis and current criteria for commercial lending. The maximum grant amount is limited to 75 percent of the cost of developing the facility. This amount cannot exceed the greater of \$50,000 or 50 percent of the total State allocation for grants. Maximum grant amounts are determined based on a tiered system which takes the population size and the income of the area into account (Table 4).

The program defines essential community facilities as “broad based, viable facilities that provide lasting services and benefits to the entire community.” Essential community facilities must meet all of the following criteria:

- Provide an essential public service to the local community - the service should be a service that is typically provided by a local unit of government;
- Be needed for the orderly development of the rural community - considered a public improvement;
- Does not include private, commercial or business undertakings; and
- Must include significant community support.” (USDA Rural Development Rural Housing Service, no date).

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<sup>18</sup> The USDA definition of “not-for-profit” requires local control of a board which has at least 25 members. This disqualifies some entities otherwise thought of as not-for-profit, such as the national Good Samaritan system which has local boards but no local board control.

## **Application Process**

The award process starts with a pre-application to the local Rural Development district office and then follows these steps (Catalog of Federal Domestic Assistance, no date):

1. Review of pre-application by the Rural Development District Director
2. Pre-application is forwarded to the Rural Development State Office for review and processing instructions
3. Following review by the State Office, the applicant is notified about eligibility, availability of funds, and if an application should be filed
4. Completion of the application
5. Approval by the State Office
6. Funds are made available to the Rural Development district office for delivery

A feasibility study of the project is required for the application. The scoring system for the applications is based on population and median household income and favors poorer, less populated areas.

It takes approximately 45 days for the determination of applicant eligibility, project priority status, and funding availability. Official estimates put the approval/disapproval time at 30 to 90 days, (USDA Rural Development Rural Housing Service, no date).

There are no application deadlines, but funds for direct loans may become scarce near the end of the fiscal year and applicants may be advised to change the mix of financing (higher amount of guaranteed loan) or postpone until the next fiscal year.

## **Terms**

The direct loan program has a three-tiered interest rate: poverty, intermediate, and market rate. The rate of the individual loan depends on the median household income in the service area and the type of project. The poverty interest rate is fixed at 4.5 percent, the maximum (market) interest rate is based on commercial bonds, and the intermediate interest is fixed at the halfway point between the poverty and market rates. Interest rates are updated quarterly. Interest rates effective until September 30, 2001 were market rate, 5.25 percent; intermediate, 4.875 percent and poverty, 4.5 percent.

Loans are limited to the lesser of the useful life of the security or 40 years. Collateral required for a direct loan may be in the form of a general obligation bond, or a note and mortgage.

**TABLE 4**  
**Maximum Grant Awards in Community Facilities Program**

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<b>% of Project Costs Maximally Awarded</b>	<b>Population</b>	<b>Median Household Income (MHI)</b>
75%	5,000 or less	Less than 60% of non-metro MHI in the state
55%	5,001 to 12,000	Less than 70% of non-metro MHI in the state
35%	12,001 to 20,000	Less than 80% of non-metro MHI in the state
15%	12,001 to 20,000	Less than 90% of non-metro MHI in the state

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Source: Parker, 2001

In the guaranteed loan program the maximum guarantee is 90 percent of the loan note. Interest rates are negotiated between the lender and the borrower. Interest cannot be tax-exempt. “The lender ... buys the guarantee from Rural Development for one percent of the amount guaranteed.” (USDA Rural Development, 2001, p.1). According to the USDA, there is no subsidy involved in the guaranteed loan program. Funds from the guaranteed lender fee have in the past offset any losses from the program (Parker, 2001).

### **Administration of the Program**

Funding decisions in the Community Facilities Program are made at the level of the Rural Development State Office (USDA). Loan and grant funds are allocated to states based on a formula incorporating the size of the rural population, unemployment rate, and the number of households below the poverty level (Catalog of Federal Domestic Assistance, no date). The state allocation formula was last evaluated after the 1990 Census and will be updated with the 2000 Census data. It is likely that some of the weights included will change. 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.

Eighty to 90 percent of the annual grant funds are allocated to the states. The rest is held as a Rural Development National Office reserve which is distributed twice a year on a competitive, project-by-project basis. The projects are scored by the Rural Development State Offices and submitted to the National Office. The program administrator has an additional 30 points to award in the scoring process.

### **Allocations/Obligations**

In the 27-year history of the program, the following amounts have been obligated:

- \$4.4 billion in direct loans (average direct loan: \$458,602)
- \$706.9 million in guaranteed loans (average guaranteed loan: \$990,038)
- \$47.9 million in grants (average grant: \$33,573)

The highest amount obligated by the direct loan program occurred in FY 2001. A total of 639 loans (\$325 million) were made. The largest obligation for direct loans to rural hospitals was made in 1978 with more than \$109 million (76 loans).

Overall, 7.6 percent of the total number of direct loans and 10.8 percent of the total number of guaranteed loans went to rural hospitals (general, surgical, and psychiatric). Direct and guaranteed loans for hospitals are considerably larger than the average loan in the program and account for 23.3 percent and 24.8 percent of the total direct loan and guaranteed loan obligations respectively (Table 5). In September, 2001 there were 646 active direct loans for a total of \$964.5 million and 65 active loan guarantees for a total of \$144.5 million to rural hospitals.

**TABLE 5**

**Community Facilities Program:  
Direct and Guaranteed Loans and Grants to Hospitals, 1974-2001**

<b>Total</b>	<b>Direct Loans</b>		<b>Guaranteed Loans</b>		<b>Grants</b>		<b>Total</b>	
Dollars	\$4.441 billion		\$706.8 million		\$47.9 million		\$5.196 billion	
Number	9,685		714		1,428		11,827	
Average Loan/Grant	\$458,602		\$990,038		\$33,573		--	
<b>Rural Hospitals</b>	<b>Direct Loans</b>	<b>% of Total</b>	<b>Guaranteed Loans</b>	<b>% of Total</b>	<b>Grants</b>	<b>% of Total</b>	<b>Total</b>	<b>% of Total Loans and Grants</b>
Dollars	\$1.036 billion	23.3	\$175.3 million	24.8	\$608,820	1.3	\$1.212 billion	23.3
Number	732	7.6	77	10.8	8	0.6	817	6.9
Average Loan/Grant	\$1,416,538	308.9	\$2,277,051	230.0	\$76,103	226.7	--	
Average Term (years)	28.6		15.1*					

Source: USDA Portfolio Data as of September 1, 2001

\*Excludes one guaranteed loan with a term of 98 years.

The loan guarantee program generally is used in conjunction with the direct loan program. Seventy-four different projects used a financing mix of multiple direct loans, multiple guaranteed loans, a mix of direct and guaranteed loans, and/or a mix of direct loans and grants.

The allocation of funds based on need is obvious in the distribution of loan funds to hospitals by Census region (Table 6). Approximately half of the direct loan funds – which are highly subsidized – went to borrowers in the South Census region. The need-based allocation is also evident in the large proportion of direct loan funds (45%) provided at the poverty interest rate (Table 7).<sup>19</sup> The allocation of funds to states and the eventual utilization of funds for fiscal year 2000 is illustrated in Table 8.

The utility of the Community Facilities Program as a capital program for rural hospitals is shown in the use of the loans and grants obtained (Table 9) – 37 percent of loans and grants were used for renovation, 31 percent for expansion, and 15 percent for new facilities. Less than one percent was used to refinance debt. The hospital loans made in the Community Facilities Program are used for major hospital projects and help maintain and enhance the rural health care infrastructure.

### **Performance Measurement**

The main performance measures for the program are the number of rural residents and rural communities served. The USDA acknowledges issues with the reliability of the data and is evaluating other performance measures that likely will be population based for future use. Last year, the Community Facilities Program served eight million people (Parker, 2001).

Another measure of performance is the ability of program management to minimize loan delinquency rates. In recent years the program has been able to maintain a delinquency rate of less than two percent which is on par with private sector loan program performance (Parker, 2001). A report from the GAO found that 3.5 percent of the outstanding principal in the guaranteed loan program was held by delinquent borrows in 1995 (Table 10) (General Accounting Office, 1996b)

### **Recommendations**

The following recommendations are divided into regulatory and programmatic suggestions that may permit the program to better address the capital needs of rural hospitals. The recommendations suggest possible ways to specifically target rural hospital needs. In addition, programmatic suggestions are presented to enhance program capacity to assess and respond to health care related projects.

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<sup>19</sup> The information on interest rate types is available for only 52.1 percent of all direct loans and should be interpreted cautiously. The USDA's Rural Development Office is aware of several concerns with its management information system and is working on improving data reliability and validity.

**TABLE 6**  
**Community Facilities Program Obligations to Hospitals by Census Region, 1974-2001**

<b>Census Region</b>	<b><u>Direct Loans</u></b>		<b><u>Guaranteed Loans</u></b>		<b><u>Grants</u></b>	
	<b>Number</b>	<b>% of Total \$ Obligations</b>	<b>Number</b>	<b>% of Total \$ Obligations</b>	<b>Number</b>	<b>% of Total \$ Obligations</b>
Midwest	225	28.2	20	10.4	3	29.1
Northeast	104	11.5	18	29.9	-	-
South	328	50.2	17	20.5	3	64.3
West	69	9.0	15	22.5	2	6.7
Puerto Rico	6	1.1	7	16.7	-	-
<b>Total</b>	<b>732</b>	<b>100.0</b>	<b>77</b>	<b>100.0</b>	<b>8</b>	<b>100.0</b>

Source: USDA Portfolio Data as of September 1, 2001

**TABLE 7****Interest Rate Types for Direct Hospital Loans in the CFP, 1974-2001**

<b>Interest Rate Type</b>	<b>\$</b>	<b>%</b>	<b>\$ (Excluding Unknown)</b>	<b>%</b>
Poverty	242.8 million	23.4	242.8 million	45.0
Intermediate	193.4 million	18.7	193.4 million	35.8
Market	103.7 million	10.0	103.7 million	19.2
Unknown	496.9 million	47.9	-	-
<b>Total</b>	<b>1,036 billion</b>	<b>100.0</b>	<b>540.0 million</b>	<b>100.0</b>

Source: USDA Portfolio Data as of September 1, 2001



**TABLE 8****Community Facilities Program Fiscal Year 2000 State Allocations and Fund Utilization\***

<b>State</b>	<b>FY 2000 Allocations</b>		<b>FY 2002 Fund Utilization</b>	
	<b>Amount (\$ millions)</b>	<b>% of Total Amount</b>	<b>Amount (\$ millions)</b>	<b>% of Total Amount</b>
Alabama	7.99	2.1	5.35	1.8
Alaska	2.05	0.5	5.17	1.7
Arizona	2.64	0.7	22.24	7.5
Arkansas	6.05	1.6	4.60	1.6
California	8.47	2.2	26.55	9.0
Colorado	2.57	0.7	3.75	1.3
Connecticut	2.24	0.6	2.79	0.9
Delaware	2.05	0.5	1.85	0.6
Florida	7.50	2.0	8.94	3.0
Georgia	10.47	2.7	6.60	2.2
Hawaii	2.05	0.5	3.27	1.1
Idaho	2.36	0.6	2.62	0.9
Illinois	8.23	2.1	4.90	1.7
Indiana	7.64	2.0	2.98	1.0
Iowa	4.87	1.3	3.76	1.3
Kansas	3.38	0.9	5.15	1.7
Kentucky	9.53	2.5	5.08	1.7
Louisiana	6.65	1.7	6.37	2.2
Maine	2.95	0.8	9.32	3.1
Maryland	2.96	0.8	6.26	2.1
Massachusetts	2.58	0.7	5.67	1.9
Michigan	11.20	2.9	14.93	5.0
Minnesota	5.86	1.5	3.96	1.3
Mississippi	8.55	2.2	3.25	1.1
Missouri	7.59	2.0	2.70	0.9
Montana	2.24	0.6	1.56	0.5
Nebraska	2.22	0.6	5.48	1.9
Nevada	2.05	0.5	.49	0.2
New Hampshire	2.19	0.6	3.24	1.1
New Jersey	2.22	0.6	1.09	0.4
New Mexico	2.65	0.7	.02	0.0
New York	9.60	2.5	10.87	3.7
North Carolina	12.96	3.4	11.00	3.7
North Dakota	2.05	0.5	5.70	1.9
Ohio	11.35	3.0	14.96	5.1
Oklahoma	5.18	1.3	2.39	0.8
Oregon	3.97	1.0	6.98	2.4

**TABLE 8 (continued)****Community Facilities Program Fiscal Year 2000 State Allocations and Fund Utilization\***

<b>State</b>	<b><u>FY 2000 Allocations</u></b>		<b><u>FY 2002 Fund Utilization</u></b>	
	<b>Amount (\$ millions)</b>	<b>% of Total Amount</b>	<b>Amount (\$ millions)</b>	<b>% of Total Amount</b>
Pennsylvania	13.45	3.5	10.62	3.6
Rhode Island	2.05	0.5	1.01	0.3
South Carolina	6.72	1.7	1.95	0.7
South Dakota	2.05	0.5	4.17	1.4
Tennessee	8.81	2.3	5.26	1.8
Texas	13.91	3.6	3.56	1.2
Utah	2.05	0.5	1.55	0.5
Vermont	2.05	0.5	1.24	0.4
Virginia	7.87	2.0	7.85	2.7
Washington	4.76	1.2	2.67	0.9
West Virginia	6.17	1.6	2.21	0.7
Wisconsin	6.70	1.7	2.90	1.0
Wyoming	2.05	0.5	2.00	0.7
West Pacific Territories	2.05	0.5	.05	0.0
Puerto Rico	13.91	3.6	17.07	5.8
Virgin Islands	2.05	0.5	.05	0.0
Reserve Program	90.57	23.6	-	-
<b>Total</b>	<b>384.49</b>	<b>100.0</b>	<b>296.27</b>	<b>100.0</b>

\*All data pertaining to direct loans, guaranteed loans, and grants made to hospitals under the Community Facilities program as of September 13, 2001 were provided by the USDA Rural Development Office and originate in the Rural Community Facilities Tracking System (RCFTS) unless otherwise noted.

**TABLE 9**  
**Use of Community Facilities Program Direct Loans,  
 Guaranteed Loans, and Grants to Rural Hospitals, 1974-2001**

Use	N	%
Renovation	299	36.6
Expansion	251	30.7
New	121	14.8
Replacement	55	6.8
Vehicles and equipment	31	3.7
Transfer of ownership	19	2.3
Restructure debt	7	.9
Transfer and assumption	2	.3
Other	15	1.8
Unknown	17	2.1
<b>Total</b>	<b>817</b>	<b>100.0</b>

Source: USDA Portfolio Data as of September 1, 2001

**TABLE 10**

**Amount of Outstanding Community Facilities Program Loans at the End of Fiscal Year 1995 and Repayment Status**

		Outstanding Principal			
		Held by delinquent borrowers		Held by current borrowers	
		Total (\$ millions)	Amount (\$ millions)	Percent	Amount (\$ millions)
Direct Loans	\$1,066.1	37.0	3.5	1,029.1	96.5
Guaranteed Loans	\$81.2	1.4	1.7	79.8	98.3

Source: General Accounting Office (1996b)

### Regulatory Recommendations

The Community Facilities Program is uniquely positioned to address the capital needs of rural hospitals and to support their role as an integral part of the local community.

1. Conduct a regulatory audit of program standards to determine if rural hospital assistance can be specifically targeted through the CFP. For example, the standards governing the allocation of CFP funding by state do not recognize the special circumstances of rural hospitals.
2. Determine if authorization exists to create a separate but coordinated set of capital initiatives for rural health care facilities as a lender of last resort for capital funding.

### Programmatic Recommendations

1. Consider increased funding to enhance the program's ability to assist critical hospital operations in isolated rural areas and to develop a technical assistance capacity for linking health care projects with general community economic development projects in ways that create synergies for the community-at-large.
  - (a) Efforts should be taken to assure that program officials have ready access to individuals with health care development and operational experience when evaluating proposed projects
  - (b) An increase in the number of USDA Rural Development field staff could increase interest in the program via enhanced outreach and education efforts
2. Conduct an assessment to determine which rural hospitals operating in sparsely populated, poor rural areas are unable to borrow at market rates and are not eligible for assistance under this program. Use these data to assess how the CFP could be modified to have a greater, longer lasting impact on the rural health care infrastructure.

## **STATE-SUPPORTED SOURCES OF CAPITAL FOR RURAL HOSPITALS**

The program and policy analyses discussed in the earlier sections of this report demonstrate that both the HUD and the USDA financial programs have made significant contributions in their own right when it comes to providing needed capital to support rural hospital projects. However, these analyses also point to how these programs have also been uneven and insufficient to handle the apparent capital need of rural hospitals. There are rural hospitals that for various reasons continue to fall short of the eligibility requirements of these programs and/or still face dwindling reserves to endorse or award the needed funds to remain viable.

Federal programs, while significant because of the amount of money available and their ability to leverage private financial markets, are only part of the capital market available to rural hospitals. Individual states represent another potential source of capital for the rural hospitals operating within their borders. A number of questions arise as to the role of state supported initiatives for addressing the capital needs of rural hospitals. Do state programs exist that

provide another avenue for rural hospitals to obtain needed capital? If so, how many are there and how do they provide the capital to rural hospitals? Where do the resources come from to support the programs? What conditions exist concerning eligibility, access to funds or their use in supporting rural hospital projects?

## **Data Collection**

A telephone survey was completed with State Offices of Rural Health to identify state-supported programs that may be available for meeting the capital needs of their rural hospitals. The survey was conducted between November 2001 and January 2002.

Forty-eight states were initially identified as potential respondents to the survey because they contained non-Metropolitan Statistical Areas. The response rate for the survey was 100 percent and forty-seven programs were found to exist within thirty-four separate states.

The primary focus of the survey was to identify those programs that were specific to a state and under the management of a state entity. A number of programs were identified through the survey that did not meet this definition:

1. The Health Finance/Facility Authorities (FHAs) programs did not provide or leverage state funding and merely provided a vehicle for qualifying for federal tax-exempt bond status (earned interest is exempt from federal taxes and in some cases state taxes as well),
2. FHA look-alikes that provided a bond vehicle for borrowers not eligible for tax exempt status,
3. a regional loan program that covered multiple states (such as the Southern Rural Access Program which is financially supported by the Robert Wood Johnson Foundation), and
4. programs that were identified but lacked either a specific vehicle for conveying capital or a history of meeting the capital needs of rural hospitals in their state (e.g., the New York Rural Health Network Development Program, a provider recruitment program in Virginia and the K. B. Reynolds Charitable Trust in North Carolina).

Following this screening 11 Health Finance Authorities, four programs under the Southern Rural Access Program (2002) supported by the RWJF, and five other programs were excluded from the analysis. Twenty-seven programs located in 22 states remained (Figure 5). Forty-six percent of states have at least one operating finance program and three states (California, Illinois, and Minnesota) have two or more programs.

## **Results**

Of the 27 identified programs, 15 were state funded, seven were funded by a mixture of sources and five were fully or partially federally funded. The most common vehicle for providing capital was grants (included in 70% of the programs) (Table 11). Direct loans was second with 25 percent and only one program offered loan guarantees, indicating that this market segment is left to other entities, such as HUD and USDA.

These data should be interpreted with a degree of caution. For example, the apparent high dependence on grants through these programs could reflect the poor financial health of the applicants (e.g. they are applying for grants rather than loans because they have doubts about their ability to repay), a preference for grant programs among institutions or organizations developing and administering these programs, or a limited availability of funds. Since grant awards are generally smaller than loans they provide only a limited ability to address capital needs. In general, grants are not sufficient to support major capital projects.

Two-thirds of the state-based programs are ongoing initiatives, while a third are temporary (e.g., initial one-time effort or a program that depends upon reauthorization of funding support). Five of the nine ongoing state-funded programs depend on recurring legislative appropriations to continue.

Of the 15 state-funded programs, nine received their funds through legislative appropriations from the general budget. Funds for six programs came from other sources (two tobacco funds, an endowment created by the state, revolving funds, a one-time appropriation and a fund fed from general revenue).

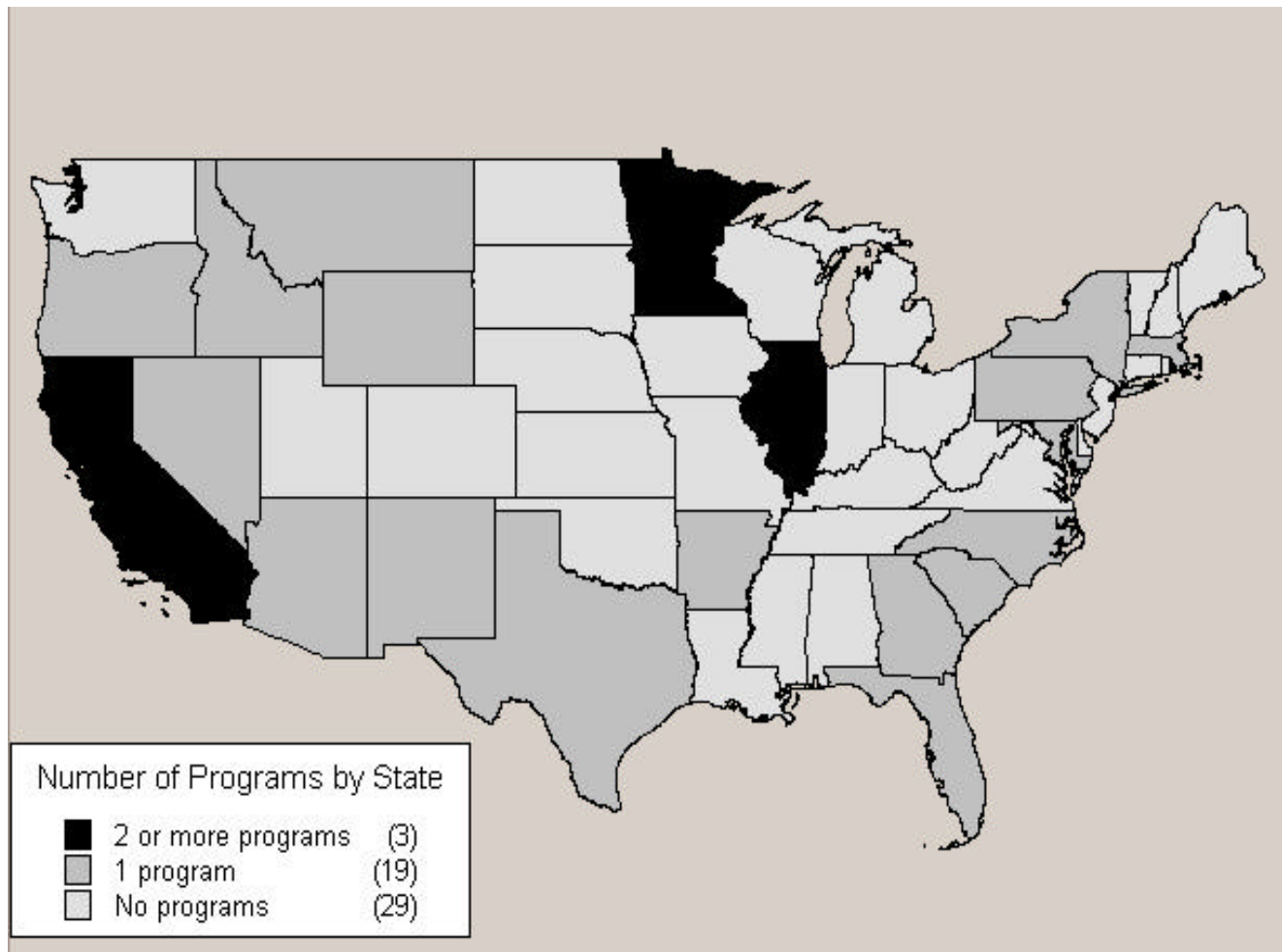
The survey identified five state-based programs that relied fully or in part upon federal funds. Two states used UPL funds for their programs, one used DSH payments, one used federal abandoned mine funds in conjunction with funds from mineral leases to finance its program, and one state has a fully federally funded program (Alaska: Denali Commission).

Approximately half of all identified programs focused on addressing hospital capital needs. Nine programs are intended specifically for rural hospitals while four others target either all the hospitals in a state or a subset of hospitals (e.g., not for profit hospitals serving the underserved, members of a hospital association). Six programs targeted either all rural health care providers or specific categories of rural health care providers (e.g., rural primary care providers). Seven programs were designed for activities that could include hospitals but did not emphasize hospital projects (e.g., primary care providers, a list of specific organizations, community development and human service facilities).

Programs that have not been designed specifically with rural hospitals in mind raise concerns about their ability to address rural hospitals' capital needs. In these kinds of programs, hospitals have to compete with other providers or organizations, and capital needs may compete with other uses of available funds, such as personnel or training. In addition, programs that do not clearly target rural hospitals may provide awards that are insufficient to address capital needs or provide funds only for very specific projects. A program's goal may be to improve access to primary care in rural areas, the program may provide funds to hospitals to improve their primary care facilities, but the use of funds is limited to that goal, enabling the hospital to improve its primary care clinic but not to improve other hospital facilities. While addressing its policy goal – the improvement of primary care services – it may not address the issue of general capital needs.

**FIGURE 5**

**Number of State Programs Addressing Rural Hospital Capital Needs by State, 2001**





**TABLE 11****Type of Support Provided by State Supported Capital Programs for Rural Hospitals (n=27)\***

<b>Type of Support</b>	<b>Number of Programs</b>			
	<b>State Funding</b>	<b>Other Funding</b>	<b>Federal Funding</b>	<b>Total</b>
Grant	12	3	4	19
Direct Loans	4	4	1	9
Loan Guarantees	1			1
Other	1		1	2

\*Some programs provide more than one type of support.

Most of the identified programs are administered or operated by state agencies. State Offices of Rural Health are at least partially responsible for nine of the programs while state departments of health are linked to four and two programs are run by state hospital or health care associations. Other entities that can share joint responsibilities with SORH, State Health Departments and State Healthcare Associations include health finance authorities, hospital consortia, and special commissions.

Two-thirds of the programs place some form of cap on the amount of support they are willing to commit to eligible entities. Detailed information on the funding levels and the number of applications and awards was available for only a small portion of the state-based programs. For the nine programs targeting rural hospitals, the number of applications during the most recent program year ranged from 2 to 220, the number of awards from 2 to 53, and the amount awarded within a program from \$20,000 to \$10 million (Table 12). The average award to a rural hospital was approximately \$74,000 (range from \$10,000 to \$189,000).

Almost one in five programs provides automatic assistance to eligible program participants (e.g., one state program awards annual funds to a statutorily defined population of rural hospitals). The remainder use a variety of criteria to define application, eligibility and award processes. For example, 41 percent of the programs indicated conditions for support with 30 percent requiring matching funds, seven percent requiring monthly and/or a final progress report and four percent requiring evidence of need.

In summary, less than half of all states have programs that may help rural hospitals address their capital needs. Grants are the preferred form of support. Funds awarded vary widely and may not be sufficient to address the most pressing capital needs of rural hospitals. A substantial number of programs depend on legislative appropriations, which in turn depend on the state of the economy. It is unlikely that these programs play a significant role in meeting rural hospitals' needs for capital.

## **CONCLUSIONS**

Efforts to address the capital needs of rural hospitals will remain complicated as the tension between rural and urban resource needs grows in the current environment of resource scarcity at the state and federal levels. It is likely to become even more polarized for states with significant differences in their urban and rural population distribution (e.g., California, Illinois and New York). When these economic pressures are coupled with the ongoing changes in medical technology and the steady aging of hospital facilities, it suggests that current estimates of rural hospital capital needs will expand in the short term.

This study has explored federal and state supported programs that hold promise for helping rural hospitals meet their capital needs to modernize and adapt their facility. Our findings on the two major federal programs (i.e., HUD 242 program and USDA Community Facilities program) indicate that only a quarter of all rural hospitals have taken advantage of either of these programs. It is unlikely that these programs will be able to expand their potential for assisting vulnerable rural hospitals that serve isolated rural communities.

TABLE 12

**Characteristics of State Supported Capital Programs for Rural Hospitals  
Only, Last Full Program Year  
(n=9)**

		<b>Rural Hospital Only Programs</b>
Number of awards to rural hospitals per program	Mean	20.7
	Minimum	2
	Maximum	53
Number of applications from rural hospitals	Mean	50.3
	Minimum	2
	Maximum	220
Success rate of applicants (Number of awards made by the program/Number of applications to the program)	Mean	69%
	Minimum	17%
	Maximum	100%
Average amount awarded to a hospital under the program (Total amount awarded to hospitals by the program/Number of hospitals that received awards)	Mean	\$74,446
	Minimum	\$10,000
	Maximum	\$188,679

Our findings indicate that the availability of state supported capital programs for rural hospitals are limited and generally not developed with the needs of rural hospitals in mind. With worsening national and state economies, we cannot expect these programs to develop into significant sources of capital for rural hospitals.

### **HUD's 242 Program**

The HUD 242 program has been successful in maintaining a low claim rate for its portfolio and at the same time has made billions of dollars available for hospital projects that otherwise might not have been completed. One quarter of a billion dollars has been made available to rural hospitals during the program's thirty-three year history. However, these funds were made available to very few rural hospitals.

The HUD and HHS officials responsible for the mortgage insurance program are sensitive to the growing capital needs and market pressures facing rural hospitals. Their efforts to identify opportunities for meeting the financial needs of rural hospitals are ongoing. An example of a recent effort is the attempt to develop additional regulatory language under HUD's 223f Program to assist hospitals in refinancing existing debt.<sup>20</sup>

The HMIP is an insurance program and must adhere to specific financial principles to sustain operations. This charge can be difficult to reconcile with the compelling delivery system issues facing rural communities. It is unlikely that a small rural hospital serving a remote and isolated rural population would be able to obtain capital from the current program (i.e., its size, capital needs and future prospects would likely work against its approval).

Recent changes, such as adding experienced health care providers to the program staff and the development of the CAH mortgage insurance provisions that allow the use of enhanced reimbursement in the calculation of insurance eligibility will help. The added flexibility in determining CAH eligibility has allowed many hospitals to qualify for insurance than otherwise would have been possible. Efforts to adapt the HUD 242 program to rural circumstances and to implement such efforts in ways that compliment existing and developing programs hold promise.

### **USDA's Community Facilities Program**

The USDA's Community Facilities Program provides loans and grants in addition to loan guarantees and offers a set of services that can more flexibly address rural hospital needs. The range of potential projects includes far more than just hospital-based initiatives, making competition for funding intense. The program is clearly targeted to rural community needs and provides a strong focus for poor and isolated communities. The program has provided significant support for rural hospital applicants whose projects comprise a substantial portion of the project portfolio. Loans to rural hospitals are, on average, larger than loans to any other entity supported by the program. Over the lifetime of the program, approximately \$1.2 billion, or one quarter of all available funding under the CFP, has been used to support rural hospital

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<sup>20</sup> The existence of a program that targets old hospital debts could make it easier to find lenders for supporting capital projects under the HUD 242 program because of the greater potential for generating income to pay mortgage fees (i.e., paying off existing debt can release committed funds devoted to high interest rates).

projects. Since its inception in 1974, the CFP has provided 817 loans, loan guarantees and grants to 734 distinct rural hospital projects. Of these projects, 37 percent involved renovation activities, 31 percent expansion, and 15 percent were used to obtain new facilities. Less than one percent of project funds were used to refinance old debt. In September, 2001, the CFP portfolio contained 646 direct loans and 65 guaranteed loans to rural hospitals for \$1.1 billion.

### **State-Supported Capital Programs**

Federal programs, while significant because of the sheer amount of money available and their capacity to leverage private financial markets, are only part of the existing capital market available to rural hospitals. Our analysis of state specific capital programs for rural hospitals focused only on those programs that operated within a given state and depended at least in part upon state financing. Half of the twenty-seven identified programs focused on addressing hospital capital needs and nine of the twenty-seven programs targeted rural hospitals specifically. The majority of the state programs included a funding ceiling and the average award for rural hospitals among all programs was approximately \$74,000. This low average for capital support is not surprising since almost three-quarters of the programs used grants as their vehicle for distributing capital among eligible applicants.

Although many states do not have the resources for establishing major, long-term capital streams for their rural hospitals, some have been able to create multiple programs. Some states (such as Minnesota) also have been able to invest in statewide assessments of rural hospital capital needs and use the data for guiding program development and implementation (Minnesota Department of Health, 2001). Other states (such as West Virginia) have invested a portion of their federal funding under the Medicare Rural Hospital Flexibility Program to assess the capital needs of a subset of rural hospitals, Critical Access Hospitals (West Virginia Hospital Association, 2001).

Many of the state programs were ongoing initiatives. Only one-third of the state programs were “one-time-efforts” or needed reauthorization to continue. However, having an ongoing initiative does not necessarily mean long-term funding is guaranteed (i.e., over half of the ongoing initiatives depend on recurring legislative appropriations and are vulnerable to short-term economic conditions). Four out of every five state programs required a competitive application process and three out of four required matching funds from the projects that were supported. Although many of the state programs target the capital needs of some aspect of their rural health care sector, the level of awards made as well as the conditions of eligibility and award receipt suggest that the programs are not sufficient to meet the capital needs of the rural hospitals in their state.

### **Postscript**

There always will be a segment of the nation’s rural hospitals that will not meet the program eligibility criteria set by programs such as the HMIP and the CFP. Some rural hospitals, because they do not or cannot participate in programs like the Medicare Rural Hospital Flexibility Program, will not be able to take advantage of initiatives such as the HUD CAH mortgage eligibility criteria. Many of these hospitals are located in states that do not have a

functioning capital funding program available and others are in states with programs whose size will depend on future economic trends.

A number of our recommendations describe opportunities for reaching out to these rural hospitals and communities. Some involve greater assumptions of financial risk. For example, the inclusion of the phrase “urgently needed” hospitals in the HUD 242 authorizing language for identifying funding priorities has been interpreted in the past as those hospital projects that are needed by the facility. However, this same language could be interpreted as defining those hospitals that are “urgently needed” by their communities for assuring access to basic health care services. In this latter interpretation, the operative premise is not what the hospital needs but what the community needs. It is possible to envision a new paradigm for the HMIP that integrates community health need with facility financial need when addressing the capital issues of small rural hospitals. The key issue is the degree to which public funds should be placed at financial risk to ensure that all Americans have access to basic health care services regardless of where they are geographically located.

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**APPENDIX A**

**HUD and HHS Responsibilities in the FHA 242 Hospital Mortgage Insurance Program<sup>1</sup>**

HUD has program responsibility and maintains an exclusive contract with HHS.

<b>Development</b>	<b>HHS</b>	<b>HUD</b>
Provide applicant guidance and assistance (including pre-application conference)	X	X
Conduct initial site visit to hospital	X	X
Review/approve construction plans, specs, and contracts	X	
Engage independent feasibility consultant		X
Recommend to HUD approval/disapproval of application and make final underwriting determinations	X	X
Legal reviews, issue commitment, close and endorse loan		X
Conduct pre-construction conference, monitor construction and process requests for advances of proceeds	X	
Review cost certification, inform lender of maximum insurable amount, and process final advance	X	
Arrange final closing and finally endorse mortgage		X
<b>Loan Management</b>		
Monitor hospital's financial performance (includes site visits)	X	X
Receive, review and recommend to HUD approval or disapproval of special requests & loan modifications	X	X
Approve special requests and loan modifications		X
Conduct site visits to troubled hospitals to determine actions needed to prevent or cure defaults	X	X
Review the quality and condition of insured hospital loan portfolio and determine amount of loan loss reserve		X
<b>Assignment</b>		
Receive/process assignment of loan and pay insurance claim		X
Review assigned hospital's operational performance and financial condition and conduct site visits as needed	X	X
Receive, review & recommend approval/disapproval of proposed workout agreements or mortgage modifications	X	X
Bill for and collect mortgage payments		X
<b>Disposition</b>		
Analyze hospital's situation, evaluate alternative uses, secure appraisal, make foreclosure decision and hold sale		X
Contract for management services and repairs as needed to protect asset if HUD is mortgagee-in-possession or acquires hospital through foreclosure or deed-in-lieu		X
Develop marketing plan, advertise and sell hospital		X

<sup>1</sup> GAO/HEHS-96-29, FHA Hospital Mortgage Insurance Program, update (Davis, 2001).

## APPENDIX B

### Minimum Criteria for Consideration for FHA Hospital Mortgage Insurance

This “Customer Self-Determination” Pre-Test offers guidelines to help potential applicants reach their own preliminary assessments on whether or not they meet the following minimum criteria for HUD Section 242 Mortgage Insurance. We invite your applications and encourage potential applicants to call a Customer Relations Representative toll-free at 1-877-262-0763. Passing the Pre-Test **DOES NOT** assure that an application will be approved.

1. Is your facility a licensed hospital? (Requisite Response: **YES**)
2. a) For the most recently completed Fiscal Year, was the total of revenues earned by delivering the following services more than 50% of the hospital’s total revenues? (Requisite Response: **NO**)
  - Chronic convalescent and rest
  - Drug and alcoholic
  - Epileptic
  - Nervous and mental
  - Mentally deficient
  - Tuberculosis care
- b) Through the end of the project construction and for two complete Fiscal Years thereafter, do you anticipate that during any Fiscal Year the total of revenues earned by delivering the above services will be more than 50% of the hospital’s total revenues? (Requisite Response: **NO**)
3. Does your State have a Certificate of Need (CON) process?
  - a) If yes, has a CON been issued?  
(Requisite Response: **YES** or **PENDING**)
  - b) If no, would the State be willing to commission or conduct an independent Feasibility Study, paid for by the hospital and which may be reimbursed from mortgage proceeds?  
(Requisite Response: **YES**)

[Notes: (1) If you have questions about your State’s CON program or do not know whom to contact, then we encourage you to contact first your State Health Planning and Developing Agency, State Hospital Licensure Agency, or State Department of Health. We are available

to answer questions that your State’s CON agency may have (e.g., through conference calls).  
 (2) If you are able to provide the requisite response to every question except this one, then please call us toll-free at 1-877-263-0763 for further consultation.]

4. After the project construction is completed, will the mortgage exceed 90% of the estimated book value of all property (existing before project, new additions and/or renovations after project) that secures the mortgage? (Requisite Response: **NO**)
5. Will you grant to the HUD-insured lender a first mortgage on the entire hospital, including all additions, annexes, parcels, and fixtures, such as parking lots, physical plants, etc.? (Note: exceptions may include leased equipment, off-site property, capital associated with affiliations, etc.) (Requisite Response: **YES**)
6. Are you willing to make monthly payments into a Mortgage Reserve Fund that will build to: (a) a balance equal to one year of debt service after five years, and (b) a balance equal to two years of debt service after 10 years? (Requisite Response: **YES**)
7. Over the last three full Fiscal Years, has the average operating margin been equal to or greater than 0.00? (Requisite Response: **YES**)

$$\text{Operating Margin} = \frac{\begin{aligned} & \textit{Operating Net Income from Last Full FY} \\ & + \textit{Operating Net Income from Two Full FYs Ago} \\ & + \textit{Operating Net Income from Three Full FYs Ago} \end{aligned}}{\begin{aligned} & \textit{Total Operating Revenues from Last Full FY} \\ & + \textit{Total Operating Revenues from Last Two Full FYs Ago} \\ & + \textit{Total Operating Revenues from Last Three Full FYs Ago} \end{aligned}}$$

(Note: Include leases in calculations for both Operating Margin and Debt Service Coverage Ratio below.)

8. Over the last three full Fiscal Years, has the average debt service coverage ratio been equal to or greater than 1.25?  
 (Requisite Response: **YES**)

$$\textit{Debt Service Coverage Ratio (DSC)} = \frac{\textit{Net Income} + \textit{Depreciation Expense} + \textit{Interest Expense}}{\textit{Current Portion of Long-Term Debt (Prior Year)} + \textit{Interest Expense}}$$

Compute the DSC for each of the last three full Fiscal Years, then compute the average DSC for the three years.

Now that you have completed this stage of the preliminary assessment, please call toll-free 1-877-263-0763 to continue the process.

Source: (BHIF, 2001)

## APPENDIX C

### HUD 242 Mortgage Insurance Underwriting Guidelines

Guidelines list review criteria in inclusive order from low risk (level one) to high risk applicants (level three) and are additive (i.e., level two projects must meet level one and level two criteria). Relative statements such as appropriate and reasonable refer to accepted industry standards.

#### **Level One**

- 1-1 Aggregate net gain from operations in past three audited financial statements (plus latest year-to-date interims) and preferably positive trends.
- 1-2 Projected gains from operations and a manageable debt load using reasonable feasibility study assumptions.

#### **Level Two**

- 2-1 Cushion in the balance sheet – the ability to withstand short periods of net losses without jeopardizing financial viability.
- 2-2 Reasonable debt load.

#### **Level Three**

- 3-1 Patient utilization forecasts (including ALOS, Case Intensity, Discharges, Area-wide Use Rates) are consistent with the facility's historical trends, future service mix, overall market trends and business climate.
- 3-2 The facility has demonstrated the ability to position itself to compete in a changing market, including markets with increasing managed care.
- 3-3 Financial and operational performance between submission of application and initial closing is in conformance with feasibility study forecast.
- 3-4 The hospital develops and maintains organizational affiliations and relationships to optimize financial and operational performance.
- 3-5 Management's demonstrated ability to operate effectively (i.e., expenses controlled/reduced commensurate with shortfalls, receivables/payables are efficiently/effectively managed, staffing/efficiency measures are within acceptable levels). Effective strategies are developed to address problems.
- 3-6 Systems are in place to accurately and timely monitor hospital operations.
- 3-7 The Board is appropriately constituted and provides effective oversight.

- 3-8 The facility has appropriate licensures/approvals (i.e., JCAHO, State, CON, etc.).
- 3-9 Projected payor rates are consistent with the political and business climate.
- 3-10 Facility has appropriate JCAHO or equivalent qualitative ratings.

In addition to these defined underwriting guidelines, program officials indicated that a variety of subjective assessments were also made during site visits and included in the overall determination of mortgage insurance eligibility.

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