Financing and Health Care Provision In Appalachian Kentucky

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Written by Judy Owens

For 30 years MACED has worked with people in eastern Kentucky and Central Appalachia to create economic opportunity, strengthen democracy and support the sustainable use of natural resources. We invest in people, businesses and organizations, conduct research to support good public policy and demonstrate alternative approaches to community economic development.

MACED • 433 Chestnut Street • Berea, KY 40403
voice/ttd: 859-986-2373 • fax: 859-986-1299 • www.maced.org

URGENT CARE:
FINANCING AND HEALTH CARE PROVISION IN APPALACHIAN KENTUCKY

A survey of more than 50 rural doctors, dentists, administrators and bankers conducted by MACED in 2005-06 showed that rural health providers need financing alternatives beyond traditional lenders to meet their needs. Traditional lenders are becoming more conservative in their lending practices to rural health care providers because of growing numbers of uninsured patients and challenges to the Medicaid system. A combination of survey and interviews, this research brief shows that:

1. *Rural health care providers in low-income and rural communities in Kentucky have the entrepreneurial capacity to meet the challenges of the current business climate, but lack access to capital necessary to start, sustain and expand services.*

2. *State and federal trends in health care financing will exacerbate the problems caused by undercapitalization of rural healthcare providers.*

3. *Traditional lenders such as local banks alone are not able to address the need for capital as many rural practitioners lack adequate collateral, have too much debt or suffer cash flow problems.*

Doctors, dentists and clinic managers in rural Kentucky hope to meet the challenges of rising rates of uninsured patients, proposed Medicaid cuts and provider shortages. This optimism is tempered, however, by a decrease in risk tolerance of traditional lending institutions when making loans for some rural health care providers. Lack of sufficient access to capital stymies the ability of rural health care entrepreneurs to invest in infrastructure and technology improvements and indicates a need for innovative solutions to complement traditional bank capital. Failure to address this trend will result in a decline in quality of health care for Kentucky's most chronically ill citizens.

SETTING THE STAGE — STATE AND FEDERAL HEALTH CARE FINANCING

"...providers still struggle with an unwieldy balancing act: finding resources to meet the needs of uninsured or underinsured people as employer-provided health insurance declines and Medicaid contracts."

Rural health care providers are disproportionately depending on Medicaid, and continuing changes in the state Medicaid program may likewise disproportionately affect rural providers, especially clinics, private doctor's offices and dental offices.

Medicaid drives the health care economy in rural communities and is the financial backbone for rural health care enterprise. According to one study, if Kentucky cuts $1 million in Medicaid funds, it would lose $4.4 million in business activity, 45 jobs and $1.5 million in salaries. Medicaid's foundation is cracking under the weight of increased costs, declining employer sponsored health insurance and rising uninsured population.[1] Federal and state officials, since the mid-1990s, have been redesigning programs to relax regulations, foster entrepreneurialism and encourage cooperative, community-based solutions.

Those who develop and sustain the health care safety net have more flexibility than when Medicare and Medicaid were first introduced in 1965. But providers still struggle with an unwieldy balancing act: finding resources to meet the needs of uninsured or underinsured people as employer-provided health insurance declines and Medicaid contracts. While the federal government offers incentives to expand safety net providers through programs such as federally-qualified health centers (FQHCs), these incentives alone are not enough to bridge the gap. Federally-qualified health centers, also created in 1965, meet strict criteria but then received an annual federal allotment to meet the needs of uninsured people, or those whose insurance does not cover all their health care needs. The Bush administration has pursued expansion of FQHCs and the centerpiece of its policy to offer health care to low-income people, either those who do not have insurance or who may need services formerly provided by state Medicaid programs. Some research indicates that FQHCs provide savings to state Medicaid programs by redirecting non-urgent and ambulatory care sensitive emergency room visits to clinics.[2]

Kentucky has 15 federally qualified health centers serving 192,220 individuals, compared with 720,000 who received services through Medicaid and 520,100 who are uninsured.[3] Although three new centers have been approved in the past two years, the development of FQHCs is slow.[4] Even when a clinic receives FQHC status, the federal grant covers only about 26 percent of the revenue of a typical FQHC, leaving these institutions still heavily dependent on Medicaid, private insurance or self-pay.[5]

Financial pressures that are squeezing Medicaid programs nationwide are also squeezing employers, especially small businesses. The rate of employer-provided health insurance declined 7 percent in Kentucky between 2000 and 2004, compared with 4.9 percent for the U.S.[6] Since 2001, about 4.6 million more Americans became uninsured and many – but not all – of those enrolled in Medicaid. This means that the burden for those who lose employer health insurance will fall on government insurance programs like Medicaid. Kentuckians are more dependent on Medicaid than the national average, with 15 percent of the non-elderly receiving Medicaid benefits as compared with 13.1 percent nationally. Medicaid is the economic bedrock for rural clinics.

The number of uninsured could increase if Medicaid rolls are reduced. While Kentucky has taken a moderate approach to Medicaid reform compared with some other states, officials do not rule out more drastic cuts in the future. Kentucky Governor Ernie Fletcher announced in late 2005 an overhaul that could reap savings in excess of $1 billion over seven years with the approval of a waiver of federal Medicaid regulations.

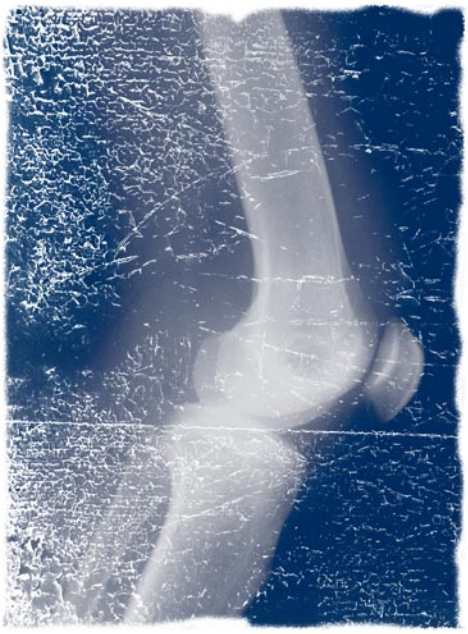
Federal policy intends that low-income people rely more on federally-qualified health centers for care because evidence suggests these centers provide better access to care and reduce inappropriate emergency room use. However, planning for conversion to FQHC status is time-consuming and complicated and clinics considering such a change must continue to operate while seeking designation.

RURAL HEALTH CARE PROVIDERS NEED CAPITAL

Some estimates indicate the cost of constructing a clinic is $125 per square foot, ... and is expected to increase to more than $150 per square foot by 2007."

MACED's survey showed that established rural clinics, doctor and dental offices need to upgrade facilities and equipment, with a demand for more than $62.5 million in facility construction, $16.7 million in equipment and $18.3 million in working capital in Kentucky's 51 Appalachian counties for the period 2005-2008. Total estimated need for the three-year period is $97.5 million.

As Kentucky moved from its mining and agriculture base into service economies in the 1980s, a number of progressive communities looked to health care as the new economic base. Economic development incentives were used to build larger and more sophisticated hospitals in towns such as Pikeville, Hazard, Corbin and Morehead. Programs such as the National Health Service Corps were used to recruit physicians. Community, technical and regional colleges ramped up academic programs to train nurses, respiratory therapists, physical therapists and laboratory technologists. Clinical practices grew, whether they were private doctors' offices, nonprofit clinics, dental offices or free-standing physical therapy clinics. A solid health care infrastructure has been developed in the region, but there is wariness by the private sector for financing operational expansions, small capital investments and short-term cash flow.



"Rural clinics are struggling to keep up with the cost of innovation, particularly in areas that require a front-end investment to improve efficiency."

While training and Medicaid reimbursement are ongoing issues, access to capital is a growing concern. MACED's survey found that physicians, dentists and other rural health care providers need capital for startup, renovation and expansion of existing facilities and equipment. MACED's survey respondents have their eye on expansion. Of 50 providers surveyed, 28 responded to questions regarding new construction or expansion. Of those 28, seven are planning to build new facilities in the next three years. An additional three are planning to make significant expansion of an existing facility. Based on extrapolations of the 50 providers surveyed to all 51 Appalachian counties in Kentucky, there is a demand for more than $62.5 million for facility construction or renovation. The providers include all licensed health care facilities in the region.[7] Some estimates indicate the cost of constructing a clinic is $125 per square foot, a level that has doubled in the past four years and is expected to increase to more than $150 per square foot by 2007.

Rural clinics are struggling to keep up with the cost of innovation, particularly in areas that require a front-end investment to improve efficiency. Many of the providers surveyed said they need funds to purchase equipment such as digital medical records, x-rays and more powerful internet service to keep up with changes in the way patient information is shared. Paper documents are so inefficient that it costs about $5 every time a paper medical record is touched. But the cost to convert to an electronic medical record system exceeds $36,000 per physician, not including necessary hardware. Eventually the cost can be recovered, since installing such a system saves up to $86,000, according to one study[8] Upgrades to diagnostic equipment such as ultrasound machines, x-ray machines for panoramic views of teeth, x-rays, new examination tables, otoscopes, ophthalmoscopes and autoclaves are among the routine and essential items that these providers say they need to purchase between 2005 and 2008. For example, the cost of equipping a dental office with three chairs was estimated by one clinician to exceed $150,000. Computer equipment and software are another ongoing and pressing need.

The demand for technology and equipment for providers in Appalachian Kentucky for the period of 2005 – 2008 is estimated to be $16.7 million, based on an extrapolation of the 50 providers surveyed to all 51 Appalachian counties. This figure includes durable medical equipment, supplies, computer equipment and software. Many need to upgrade office computer equipment. Upgrades of one office system often leads to the need to upgrade other systems. For example, the transition to digitalized patient records means the eventual need for equipment to produce digitalized x-rays and other diagnostic tests. Survey results indicate a demand for more than $18.3 million in working capital for the period of 2005-2008 in Kentucky's 51 Appalachian counties

David Bolt, chief operating officer and director of planning and business development for Lewis County Health Care, regularly cited as one of the most innovative federally-qualified health centers, said there is a chronic need for capital for land acquisition, equipment, building construction and cash flow for initial start-up. Bolt's observation is typical of other survey respondents. Once construction is complete, clinics must be outfitted with examination tables, exam stools and lights, x-ray equipment, hand tools and scales. Of those surveyed, a third expressed an immediate need for new equipment to keep pace with patient demand.

Gerry Roll, executive director of Hazard-Perry County Community Ministries, a social service agency based in Hazard, has won national recognition for getting services to uninsured rural homeless people using "clinics without walls" - using lay health workers to match up patients with volunteer nurses and doctors in informal settings. This strategy allowed Roll's organization to deliver basic health care to low income patients at a minimal cost because patients were seen in space that was donated by church or civic groups, or patients were linked with physicians to be seen at their offices. But at some point, Roll said, a physical facility with appropriate equipment is necessary to sustain services.

TRADITIONAL BANKS FACE CONSTRAINTS

"Several bankers said that financing new practice start-ups is problematic. ...there is no ready source of funds available to meet these needs."

MACED's survey shows that primary care and dental start-ups and expansions need technology, medical and dental equipment, while traditional banks are being required to reduce risk in the face of uncertainty in rural health care reimbursement.

Lenders are wary of making large, under-collateralized loans, particularly with the high debt-to-equity ratios of many rural healthcare providers with tenuous streams of cash flow supporting the debt service.

"Not a lot of banks are going to loan you a huge amount of money when they know that a third of your patients can't afford to pay," said one clinic administrator.

Lack of access to capital has been a persistent problem for low-income and rural communities. A recent white paper by the Association for Enterprise Opportunity cited the lack of affordable, adequate credit products and services for the low-income entrepreneur as a chief obstacle facing rural areas[9] One recent study involving Arkansas and Kentucky made specific findings regarding the need for improved affordable credit for rural entrepreneurs.[10] Because Kentucky is more rural than most states, vital resources, including the capital, talent and support needed to sustain entrepreneurship, are significantly diluted in many rural communities.[11] Physicians completing their residency programs are graduating with large debt, many with more than $115,000 in educational loans.[12] Student loan burden for dentists is even higher, with the average at 122,491.[13] Once newly-licensed physicians begin practicing, they cannot begin billing insurance companies for their services until they are credentialed, a process that requires from three to six months. If a physician completed a residency outside the Commonwealth, as many who work in underserved rural communities do, another three to six months may be required to obtain a Kentucky license. While the earning power of these practitioners is strong over the lifetime of their practices, initially newly-licensed physicians and dentists may experience significant cash flow problems.

"A recent white paper... cited the lack of affordable, adequate credit products and services for the low-income entrepreneur as a chief obstacle facing rural areas."

MACED's survey showed that rural health care reflects the same issues as other rural entrepreneurs. Most small businesses in the health care sector anticipate need for capital to build new facilities, expand existing facilities or purchase new equipment. Health providers need flexible and innovative payment options. Fifty-seven percent of the respondents to MACED's survey said they can repay loans from patient revenue yet operate on a severely limited margin. Funds to pay staff that is not in direct patient care are very limited. "I figured it up the other day," said one rural clinic manager, "Our overhead for personnel – anyone who is not in direct patient care – is only 7 percent."

On average half of the assets of these facilities are pledged as collateral, while others have more than 80 percent of their assets standing good for loans. Fully one third said that capital for equipment was the most significant need for their organization, followed by the need to upgrade aging facilities, the need to build new facilities and the need for more computer equipment and software.

Kentucky bankers echo the concerns regarding lack of collateral. Uncertainty in the future of Medicaid has caused some Kentucky bankers to employ a lower debt-to-equity ratio when calculating loan limits. The same factors have led banks to require more security for cash-flow loans and start-up lines of credit, especially for dental and nonprofit practices that lease their facilities and are therefore under-secured. Additional uncertainty related to skyrocketing malpractice insurance premiums has exacerbated the problem for traditional lenders.

Mature health care businesses are generally able to borrow from most banks at 80-90 percent loan-to-value for projects with a strong cash flow position and real property assets. For health care projects that are heavily dependent on Medicare/Medicaid reimbursements, one bank in the region said that it is considering decreasing its exposure to a 60 percent loan-to-value maximum. With real estate, the loan-to-value rate would be 70 percent coverage.

One banker indicated that for cash flow lending the bank prefers $1.25 in debt service coverage for every $1 it loans. With a higher percentage of the cash tied to Medicaid/Medicare, banks can be expected to look for a higher coverage ratio beyond 125 percent. Several bankers said that financing new practice start-ups is problematic. State loan forgiveness and low-interest loan programs have been cut, and there is no ready source of funds available to meet these needs. Although new doctors have the potential to be strong earners, they are not strong candidates for new practice startup funds because of high education debt. Rural practices are viewed even less favorably because earnings potential is weaker in rural areas for primary care medical practices or dentistry. Bankers surveyed felt that they would not look favorably on a rural private practice startup that didn't have three years of maturity building a customer base.

MACED's survey documented a need for primary care and dental start-ups and expansions. Forty-four percent of the respondents said they needed outside funding for projects at least annually.

CONCLUSION

Rural health care providers are highly dependent on Medicaid, and the shrinking Medicaid system underfunds rural providers. Banks are highly regulated and tend to be stricter regarding collateral for loans. For that reason, rural health care providers cannot rely on traditional banks alone. For nonprofit providers, grant funds are highly competitive and often non-recurring, and so while granting agencies may provide funds for demonstration projects, they cannot be relied upon for sustained capital. Providers need access to capital to take advantage of opportunity to streamline services and offer new services to respond to market needs. Traditional banks are not expected to be able to meet the need and innovative solutions will be required to address the problem if rural health care providers, who aspire to help this most needy population, will be able to meet the demand for their services.

Newly-graduated physicians and dentists have high debt and little collateral just out of school, but also have excellent long-term earning potential. Federally-qualified health centers receive a federal grant to offset the cost of patients who cannot pay for care and who do not qualify for insurance, but as a practical matter these clinics must be operating before the grant funds are approved. Once a FQHC is operational and is approved for grant funding, it typically remains solvent. Technology and equipment expenses can save money in the long run, but are often difficult to finance because of short-term liquidity problems. These needs and opportunities reflect the potential for how creative lending can improve the ability of rural communities to service the health care needs of their citizens.

Endnotes

1 "Medicaid: Good Medicine for State's Economies." Families USA 2004

2 National Association of Community Health Centers. *Nation's Health at Risk Part II: A Front Row Seat in a Changing Health Care System.* Special Topics Issue Brief #7. August 2004. www.nachc.com.

3 Kaiser Family Foundation State Health Facts Online. It should be noted that Medicaid is accepted at federally-qualified health centers, so some of the patients seen at FQHCs would also be counted among those served by Medicaid.

4 Newly created Community Health Centers in Kentucky are Juniper Health, Inc., serving Breathitt, Wolfe and Lee counties; Kentucky River Foothills clinic serving Estill and Powell counties and the North Forth Valley Clinic, based in Hazard and serving parts of Leslie and Knott counties.

5 Bureau of Primary Health Care, HRSA, Uniform Data System, National Rollup Reports 2000-2003.

6 State Medicaid Fact Sheet. The Kaiser Commission on Medicaid and the Uninsured.

7 The number of facilities was obtained from the Cabinet for Health and Family Services, Office of Inspector General "Directory of Licensed Health Care Facilities Miscellaneous Directory" June 1, 2006, which lists all licensed facilities in 21 categories throughout the state.

8 Wang, Samuel J., M.D., Ph.D.; Middleton, Blackford, J.D., M.P.H, MSc, Prosser, Lisa A. Ph.D.; Bardon, J.D. Christiana, et. al., A Cost-Benefit Analysis of Electronic Medical Records in Primary Care. The American Journal of Medicine, April 1, 2003, Vol. 114.

9 Rural Committee White Paper Key Issue Areas for Rural Entrepreneurship Policy. Edited by Karen A. Dabson. 2005. http://www.microenterpriseworks.org/projects/ruraldevelopment/ruralpolicy/Key-Issue-Areas-Rural-Ent.htm

10 Mocker (Dabson), K. and J. Potter. 2000. *Three Kentucky Counties: Clay, Jackson, and Rockcastle.* Cleveland: Federal Reserve Bank of Cleveland. Also, see Dabson, K. 2002. *Changing the Face of Rural Entrepreneurship: Building Better Businesses Through a Regional Model of Cooperation.* Campbellsville, KY: Community Ventures Corporation and Team Taylor County. Also see, Dabson, B. and K. Marcoux, 2002. *Entrepreneurial Arkansas: Connecting the Dots.* Washington, D.C.: CFED.

11 Entrepreneurs and Small Business: Kentucky's Neglected Natural Resource. 2005 (unpublished – available on web at http://www.kltprc.net/books/ENTREP.HTM

12 American Medical Association estimates that the average physician in 2004 left medical school with $115,218 in educational debt. The average was even higher for osteopaths, whose mean per capita debt was $123,800. http://www.ama-assn.org/ama/pub/category/5349.html

13 American Dental Association Managing Finances 2005.