

# Community Developments *Investments*

June 2016

## Financing Health Centers Supporting Community Wellness



# Financing Health Centers

## Supporting Community Wellness

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# A Look Inside ...

Barry Wides, Deputy Comptroller, OCC

Federally qualified health centers (FQHC or health centers) provide life-sustaining services to residents in economically challenged neighborhoods. National banks and federal savings associations (collectively, banks) serving these neighborhoods are increasingly helping to provide the financing that sustains these health centers so they can do their good work.

This issue of the Office of the Comptroller of the Currency's (OCC) *Community Developments Investments* examines how banks are taking advantage of new and expanding opportunities to finance the approximately 1,300 federally funded health centers nationwide that serve economically disadvantaged communities.

The opportunities for banks are growing, thanks in part to the increased demand health centers face from millions of formerly uninsured individuals who now have health insurance under the



Unity

**Unity Health Care Inc. offers primary health care services in Washington, D.C., to the homeless, working poor, and families, as well as to those who are uninsured and living with HIV/AIDS and hepatitis, regardless of their ability to pay.**

Affordable Care Act (ACA). The partnership is mutually beneficial. Because demand for health centers has doubled since 2002 and is predicted to double again by 2020 to more than 32 million patients, the industry needs bank financing to expand. Banks looking to expand their lending and fulfill Community Reinvestment Act (CRA) commitments may achieve both objectives by helping finance the more than \$8.5 billion needed by 2020 to finance the necessary expansion.

They were called neighborhood health centers when established by President Lyndon Johnson's War on Poverty and the Economic Opportunity Act of 1964. Today, they go by many names—FQHC, health center, community health center, health clinic, and more—

and are essential to the nation's health care safety net as providers of primary health care and social services to residents in low-income and medically underserved communities.

FQHCs receive federal grant funds under section 330 of the Public Health Service Act (PHSA), codified at 42 USC 254(b), and enjoy preferential, cost-based reimbursement under Medicaid and Medicare programs. Because of insufficient federal funds, not all health centers receive section 330 grant funds. Health centers that do not receive section 330 grant funds are referred to as FQHC look-alikes. Thanks to the section 330 grants they receive, FQHCs have an unusual business model.

Federal funding, however, fulfills

## Community Developments

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This and previous editions are available at [www.occ.gov/cdd/resource.htm](http://www.occ.gov/cdd/resource.htm).

### On the cover

Buildings pictured: Erie HealthReach Waukegan Health Center, Waukegan, Ill. (top left), Brockton Neighborhood Health Center, Brockton, Mass. (center right), Whitman-Walker Health Center, Washington, D.C. (center).

### Disclaimer

Articles by non-OCC authors represent their own views and not necessarily the views of the OCC.

only part of the financing equation, and this is where banks can play a critical role.

Inside this *Community Developments Investments*, you will find informative articles, written by bankers and other industry experts, that explain the FQHC financing landscape and the tools banks need to support health centers. I am grateful to our external contributors for their insights, which represent the authors' own views and not necessarily the views of the OCC.

I know you will find the following articles helpful:

- *Peg Underhill of Capital Link* explains the growing demand for health centers and that financing has been secured for only 25 percent of \$8.5 billion in planned projects in **“Investing in Expanding Health Centers.”**
- *Annie Donovan of the Community Development Financial Institutions (CDFI) Fund and Pam Porter of Opportunity Finance Network* explain in **“Health Care Financing and CDFIs”** the compelling financing opportunity banks and CDFIs have in health center expansions.
- *Scott Spote of Capital Impact Partners* explains in **“Financing Health Centers”** that well-managed health centers operate profitably and have a very low rate of loan default. He discusses plans for 1,000 new health center projects—investments in excess of \$7 billion in the next five years—and spotlights a Hagerstown, Md., and a central California coast health center.
- *Local Initiatives Support Corporation’s (LISC) Kevin*

## What Are Federally Qualified Health Centers?

*Wendy Takahisa, Executive Director, Community Reinvestment Act, Morgan Stanley*

Federally qualified health centers (FQHC or health center) are community-based organizations that provide comprehensive primary care and preventive health care to underserved, underinsured, and uninsured Americans, including migrant workers and non-U.S. citizens. FQHCs provide their services to all persons regardless of ability to pay, and they charge for services on a community board-approved sliding fee scale. The alternative for those who cannot otherwise afford or easily access health and dental care is to use hospital emergency rooms, care that does not focus on prevention or provide the continuum of care

that is especially essential for children and seniors.

FQHCs operate under a consumer board of directors governance structure and function under the supervision of the U.S. Department of Health and Human Services. According to Capital Link, a nationally recognized authority in this field, FQHCs “also help patients gain access to social services and legal aid.”

*For more information, e-mail Wendy Takahisa at [wendy.takahisa@morganstanley.com](mailto:wendy.takahisa@morganstanley.com).*

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*Boes* discusses in **“Leveraging Nontraditional Alliances”** how LISC teamed with Morgan Stanley and the Kresge Foundation to launch the Healthy Futures Fund, an investment providing health services to affordable housing residents. *Kresge’s Kimberlee Cornett* explains the benefits of partnership in **“Catalyzing the Investment.”**

- *Lindy Hahn of Morgan Stanley* notes the link between poverty and health and explains the benefits of partnership to improve well-being in **“Collaboratively Financing Healthy Futures.”**
- *Kevin Goldsmith of JP Morgan Chase Bank, N.A.* explains in **“Beneficial Partnerships, Missions, and Values”** how his bank, working with CDFIs and New Markets Tax Credits, is helping health centers expand and deliver primary care to more than 20 million low-income and uninsured patients.
- In **“Federal Government Support: Guaranteed Loan Funds,”** the *OCC* highlights loan and grant programs by the U.S. Department of Health and Human Services and the U.S. Department of Agriculture that support health centers. The *USDA’s Terence McGhee* explains the agency’s program in **“USDA’s Community Facilities Guaranteed Loan Program.”**
- For other helpful information, read **“Community Reinvestment Act and Health Center Financing”** by the *OCC’s Vonda Eanes*, **“What Are Federally Qualified Health Centers?”**, the **Health Center Resource List**, and **Health Center Terminology**.

## Community Reinvestment Act and Health Center Financing

Vonda Eanes, Community Affairs, OCC

Federally qualified health centers (FQHC) are valuable community resources. Are bank activities that support health centers considered to meet the definition of community development under the Community Reinvestment Act (CRA)? To answer this question, we need to ask and answer several underlying questions.

### Background

Banks have an obligation under the CRA to help meet the credit and deposit service needs of the communities where they are chartered to do business. In general, such communities are where a bank has at least one deposit-taking automated teller machine or branch. To help meet community needs, banks that meet certain asset thresholds must also provide community development loans, qualified investments, or community development services, or some combination thereof. The OCC is required to evaluate whether each bank is meeting its obligation, consistent with the safe and sound operation of the institution.<sup>1</sup>

The CRA definition of community development includes community services targeted to low- and moderate-income (LMI) individuals.

The *Interagency Questions and Answers Regarding Community Reinvestment* (Q&A) clarifies how bank loans, investments, and services that support organizations or activities that have a primary purpose of community development may be considered during the course of a CRA performance evaluation.

### Defining Community Services

While the term “community services” is not defined in the CRA or its implementing regulations, one of the examples of community services in the Q&A includes health care facilities that provide services for LMI individuals.<sup>2</sup> Health centers provide primary and supportive health care services to designated populations.

### Determining Whether Services Are Provided to LMI Individuals

The Q&A explains how a bank may determine whether a community service is provided to LMI individuals.<sup>3</sup> For example, the community service may be provided by an organization with a defined mission of serving LMI individuals. Alternatively, the organization may have a clearly defined community service program that benefits primarily LMI persons even if the service is provided by an entity offering other programs that serve individuals of all income levels. The service may be conducted in an LMI area and targeted to residents of the area or offered by a nonprofit organization that is located in and serves an LMI geography. The Q&A notes that a community service can be considered to serve LMI individuals if it is targeted to individuals who receive or are eligible to receive Medicaid.

### Meeting the Definition of Community Development

Health centers do not limit services to individuals defined as LMI under the CRA but instead serve areas or populations defined as medically underserved. Although the CRA and health centers define their target populations differently, statistics show the primary beneficiaries of health centers would generally meet the definition of an LMI individual under the CRA.<sup>4</sup> Not all health centers, however, are federally qualified to be Health Resources and Services Administration funded. Banks should be prepared to provide evidence that activity supports a health center that primarily serves LMI individuals.

*For more information, e-mail Vonda Eanes at [vonda.eanes@occ.treas.gov](mailto:vonda.eanes@occ.treas.gov).*

<sup>1</sup> 12 USC 2901

<sup>2</sup> *Interagency Questions and Answers Regarding Community Reinvestment*, 75 FR 11642-11647 (March 11, 2010) (Q&A 12 CFR \_\_12[t]-4)

<sup>3</sup> *Interagency Questions and Answers Regarding Community Reinvestment*, 78 FR 69671-69680 (November 20, 2013) (Q&A 12 CFR \_\_12[g][2]-1).

<sup>4</sup> Data from the Health Resources and Services Administration, a division of the U.S. Department of Health and Human Services (HHS), show 72 percent of patients receiving services in 2013 had incomes at or below 100 percent of poverty guidelines set by HHS.

# Investing in Expanding Health Centers

Peg Underhill, Director of Marketing, Communications, and Development, Capital Link

As Affordable Care Act (ACA) implementation proceeds, demand for primary health care is increasing, especially in low-income communities where residents are newly eligible for insurance. Federally qualified health centers (FQHC or health center) are well-positioned to respond to this demand but are challenged by the reality of expanding capacity with limited resources.

The funding environment for health centers has become increasingly uncertain and competitive, and, realistically, it will provide capital for only a small percentage of the health centers that need to renovate or build new facilities. Finding new ways to support the growth of health centers is crucial because these safety net providers contribute to the stability and development of communities across the country.

## Providing Comprehensive Care

Health centers are community-based, patient-directed organizations that provide comprehensive medical services—including primary and preventive care, dentistry, and mental health/substance abuse services—to persons of all ages, regardless of their ability to pay. Health centers also provide supportive services, such as education, translation, and transportation, which make it easier for residents to access health care. By meeting select criteria, such



Opportunity Finance Network

**Capital Link's lending affiliate, Community Health Center Capital Fund, and Local Initiatives Support Corporation financed the expansion of Katy Trail Community Health's medical and dental services.**

as serving underserved areas or populations and offering a sliding fee scale, health centers receive benefits, such as grants under section 330 of the Public Health Service (PHS) Act, and enhanced reimbursement from Medicare and Medicaid.

Federal funding, most recently from the American Recovery and Reinvestment Act of 2009 and the ACA, has resulted in a \$12.5 billion increase in investments in health center property, plant, equipment, and leased space and in the number of health center patients nearly doubling over the past decade.<sup>5</sup> With the goal

of expanding capacity to serve 32 million patients, up from 22.8 million in 2014 (see figure 1), in the coming years, additional growth is expected and investment is needed.

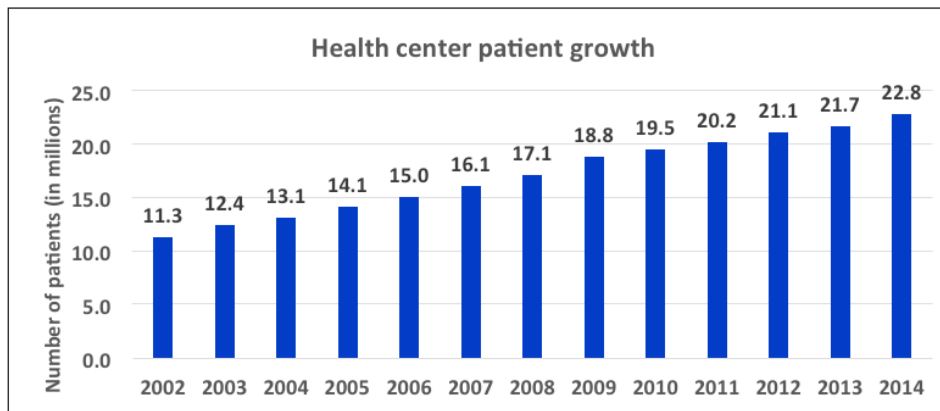
## Expanding Needs

Many health centers operate in older buildings (20 to 110 years old). In a study released by Capital Link in October 2015,<sup>6</sup> 79 percent of health centers indicated they had specific plans to initiate capital projects within the next several years, representing 2,300 potential capital projects. These projects would allow health centers to serve an additional

<sup>5</sup> National Association of Community Health Centers, *A Sketch of Community Health Centers Chart Book 2014*, federally funded health centers only. 2001–2012 Uniform Data System, Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services.

<sup>6</sup> Capital Link, *Capital Plans and Needs of Community Health Centers: A National Perspective*, October 2015.

**Figure 1. Health Center Patient Growth, 2002–2014**



Source: Capital Link

5.4 million patients—considerably short of the 10 million additional patients expected to seek care at FQHCs by 2020. In order to achieve the goal of serving 32 million patients by 2020, health centers will likely need to invest \$8.5 billion (based on Capital Link’s 2015 needs assessment) in new physical infrastructure, which is almost \$4 billion more than currently anticipated. Funding for health center-owned projects, however, has been identified and secured for only 25 percent of these planned projects.

Although additional federal capital grants may be on the horizon, supplemental funding sources are needed to fill the gap. This gap represents a window of opportunity for health centers.

## Financing Growth

Health centers are actively seeking alternative funding sources to meet growth plans and are looking to lenders and investors, including community development financial institutions (CDFI), to finance growth.

Many lenders that look closely at

the health center business model find health centers are worth the risk. Capital Link conducted a survey of 16 CDFIs working in partnership as the Lenders Coalition for Community Health Centers, an advocacy and information-sharing collaborative that represents the most active CDFI lenders providing financing to the health center industry. The survey found that the incidence of health center failure and loan default is quite low (1 percent) and has remained low for some time.<sup>7</sup> This finding is the case even though, as mission-based organizations, health centers operate with thin margins and limited cash, and tend to allocate resources to improving community health rather than building reserves.

Other Capital Link studies of the health center sector support the finding that the health center business model, when well implemented, can responsibly use debt to fuel growth. For the typical health center, leverage is low and cash available for debt service is relatively untapped, suggesting an increasing number of health centers can secure debt as a way to accelerate and manage their

growth.<sup>8</sup>

## Federal Support

The U.S. Department of Health and Human Services (HHS) has provided a number of resources to assist health centers in planning for operational growth and facilities expansion. In fact, Capital Link was established through a cooperative agreement by the Health Resources and Services Administration (HRSA) within HHS to provide planning and financing resources to health centers struggling with facilities and operational expansion.

Supported by the HRSA cooperative agreement, Capital Link offers a range of technical assistance to health centers, depending on their needs and progress in planning for a capital project. Capital Link’s protocols include assessing the health center’s capacity to expand by determining its financial strengths and weaknesses, offering comparative data on typical project costs based on the approximate size of the proposed facility, and pinpointing the health center’s ability to finance a defined capital project.

This analysis allows health centers to estimate the approximate debt and equity they need to accomplish their goals and provides a general overview of possible funding sources, considering project size, location, and other funding criteria. These sources may include New Markets Tax Credits, loans and loan guarantees from the U.S. Department of Agriculture, conventional loans from banks, state financing programs, tax-exempt

<sup>7</sup> Capital Link, *Community Health Center Perspectives: Identifying the Risks of Health Center Lending: A Guide for Lenders*, October 2014.

<sup>8</sup> Capital Link, *Community Health Center Perspectives: Financial and Operational Ratios and Trends of Community Health Centers, 2008–2011, a Guide for Lenders*, March 2014.

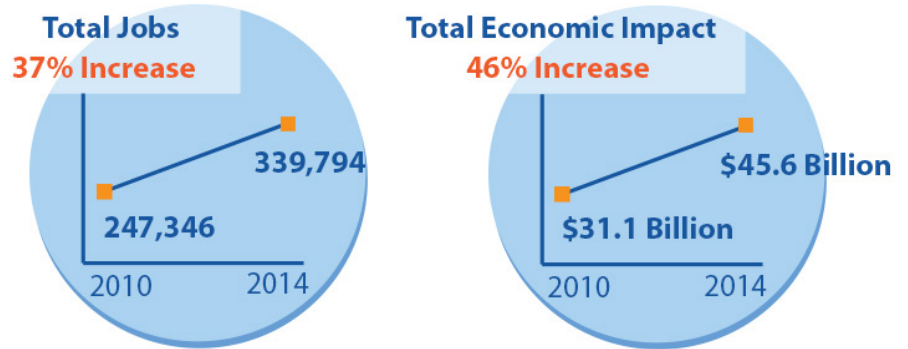
bonds, and loans from CDFIs, often in combination.

Other types of Capital Link assistance work to build health center capacity to achieve successful project completion, including providing resources related to strategic planning; market assessment; program, staff, and space planning; business planning and financial projections; design development; financing (including fundraising and debt financing); building phases; and making the new facility operational. These activities are supported by a range of written, electronic, and web-based resources, as well as frequent training sessions on capital development topics and improving financial and operational performance in preparation for growth. Written resources and webinar recordings are available to health centers and primary care associations through Capital Link's website, free-of-charge through HRSA's support.

## Educating Lenders

To encourage greater knowledge and understanding of the health center industry among capital funding sources, training and educational materials have also been offered to lenders. For example, the U.S. Department of the Treasury's CDFI Fund supported a capacity-building initiative enabling CDFIs to develop the skills to successfully finance community health centers in medically underserved markets. The Opportunity Finance Network partnered with Capital Link and other leading industry experts to offer CDFIs six free two-day

**Figure 2. Health Center Economic Impact and Job Increases, 2010–2014**



Source: Capital Link

training workshops from January through June 2014, providing a comprehensive overview of the health center landscape and how CDFIs can provide financial services to health centers. Resources from these training workshops are available.

## Community Impact

Investing in health center growth provides numerous community benefits. In addition to expanding access to health care in disadvantaged areas and preventive care that reduces overall health care costs, health center growth generates jobs and tax revenues and attracts new businesses to low-income communities. Studies point to a definite link between access to affordable health care and entrepreneurship and small business development.<sup>9</sup>

These community impacts can be measured. Using an integrated economic modeling and planning tool called IMPLAN and the latest data from HRSA's Uniform Data Systems, Capital Link recently completed an analysis to capture the

economic benefits of health centers nationally (see figure 2). Health centers collectively generated more than \$45.6 billion in total economic activity for their local communities in 2014, a 46 percent increase since 2010. Employment grew from 247,346 jobs in 2010 to 339,794 jobs in 2014, a 37 percent increase.<sup>10</sup>

Because of their success in delivering care and their increasingly important role, health centers continue to receive bipartisan support. Providing new capital funding sources to health centers will help them fulfill their crucial role in serving the newly insured and remaining uninsured populations as health reform proceeds.

*For more information, e-mail Peg Underhill at [punderhill@caplink.org](mailto:punderhill@caplink.org).*

Articles by non-OCC authors represent the authors' own views and not necessarily the views of the OCC.

<sup>9</sup> See the U.S. Small Business Administration website: <https://www.sba.gov/content/affordable-care-act-training-materials>.

<sup>10</sup> Capital Link, *Health Centers Have a Powerful National Impact*, January 2016.



## Health Care Financing and CDFIs

Annie Donovan, Director, Community Development Financial Institutions Fund, and Pam Porter, Executive Vice President, Strategic Consulting, Opportunity Finance Network

The future of American health care is tilting toward more primary care and preventive care. The need for health center services is projected at 32 million patients by 2020, according to the National Association of Community Health Centers and the Health Resources and Services Administration. As a result, health centers, including federally qualified health centers (FQHC), are poised to continue growing to meet the need for these new health care services in medically underserved communities. Financing for health centers to meet these needs and expected increasing demand is a growth market for both community development financial institutions (CDFI) and banks.

### Financing Outlook

For banks and CDFIs, there is a compelling opportunity because health centers have a projected need of \$10.3 billion (based on Capital Link's 2014 needs assessment) for capital over the next five to 10 years, as estimated by Capital Link.<sup>11</sup> For health centers to meet their communities' demands for primary care services, more banks and CDFIs must finance health centers, independently and in collaboration.

The CDFI Fund is committed to improving the quality of life and economic opportunity in low-income communities, and affordable health care is a significant part of that equation. In 2013, however, only a few CDFIs had extensive experience financing community health centers. To help address the experience gap among CDFIs, the CDFI Fund began a nationwide capacity-building initiative to provide technical assistance and training on financing community health centers for interested CDFIs. The CDFI Fund contracted with Opportunity Finance Network to develop and deliver training and technical assistance to CDFIs and other financial entities that could then deliver financial products and services directly to health centers serving underserved communities.

Opportunity Finance Network partnered with experienced and innovative practitioners in the health



Source: Opportunity Finance Network

**Tom Manning of Harbor Road, a founding staff member of Primary Care Development Corporation, speaking at an Opportunity Finance Network workshop.**

center financing field. Together, they brought the latest information on financing for health center facility rehabilitation and growth. While few CDFIs have historically lent to health centers, those that have can point to impressive track records in this sector. Capital Impact Partners, Primary Care Development Corporation, and Capital Link together demonstrate decades of CDFI experience, thousands of health center transactions, and billions of dollars of financing. These organizations know the business models of health centers, how to evaluate management capability, and the indicators to assess and manage risk in lending to health centers. While the past is no guarantee of the future, experienced lenders report the history of troubled loan ratios to be less than 1 percent.

### Training

Initial training and resource materials were offered to CDFIs through a series of two-day training sessions across the country. The series included a historical perspective on health centers as background for these mission-driven nonprofit organizations. In addition, the training looked at how the expanding numbers

<sup>11</sup> Capital Link, *Capital Plans and Needs of Health Centers: A National Perspective*, 2014.

of insured Americans are increasing the overall demands for affordable, quality health services. Both in-person and online training was provided on topics such as health care sector trends, community needs assessment, underwriting, program designs for lending to health centers, and other relevant topics. During the training, 10 chief executive officers from health centers across the country attended and explained their business models and experiences seeking financing. This synergy provided lenders with important insights into the challenges and opportunities facing health centers in today's environment.

Following the success of the live training, the CDFI Fund is providing an electronic resource bank of written materials on its website for CDFIs and other users. In addition, the CDFI Fund has conducted a series of five webinars that complement the written materials. Materials are available at the CDFI Fund's website.

Opportunity Finance Network worked with industry experts to develop the training support materials for the training sessions and the webinars, which are available on the CDFI Fund's website under Financing Community Health Centers Resource Bank: Training Curriculum. Topics include

- understanding the landscape,
- underwriting, and
- using benchmark data to evaluate operating performance.

Over 200 people working with 60 CDFIs and partner organizations, including 10 representatives of seven banks, took part in this training. Many of the attending organizations now are developing plans to build relationships with health centers in their communities and to learn about their financing needs for

- facility acquisition and development,
- facility refurbishment and expansion,
- equipment purchase, and
- working capital.

## Partners

CDFIs, especially unregulated loan funds, have flexibility to lend to health centers in ways that can be challenging for regulated banks. The most obvious example is the financing of a facility in a low-income community. It is not unusual for the cost to build or renovate a health center facility to be more than its appraised value, or at least to exceed loan-to-value (LTV) thresholds of most banks. CDFIs' loan funds can often, however, work with greater flexibility to structure loan terms to mitigate this challenge. Key to successful financing is understanding the business models and cash flows of the health center. This understanding helps CDFIs make loans based on real-time business operations, rather than the LTV or collateral coverage ratios typical in commercial real estate loans.

CDFIs can also assist with bringing in additional financing opportunities, such as the New Markets Tax Credit (NMTC), to FQHCs. NMTC deals can provide equity and interest rate cost benefits to FQHC projects located in eligible low-income and distressed communities. CDFIs experienced in NMTC transactions can provide trusted counsel and education to support health centers with NMTC deals, resulting in more successful transactions.

As Opportunity Finance Network and the CDFI Fund see it, there are many opportunities for banks, CDFIs, and health centers to work together to ensure that primary health care services are available to all communities across the United States.

*For more information about CDFIs or the CDFI Fund, visit the fund's website at [www.cdfifund.gov](http://www.cdfifund.gov) or e-mail Annie Donovan at [donovana@cdfi.treas.gov](mailto:donovana@cdfi.treas.gov).*

*For more information about Opportunity Finance Network, e-mail Pam Porter at [pporter@ofn.org](mailto:pporter@ofn.org).*

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# Financing Health Centers

Scott Sporte, Chief Lending Officer, Capital Impact Partners

Health centers meet the primary health care needs of millions of the nation's Medicaid-eligible and uninsured patients in urban and rural areas long underserved by private practice physicians. Recently celebrating the 50th anniversary of their creation, health centers have grown in size and scope to nearly 1,300 nationwide. They offer a range of comprehensive primary care, dental, and behavioral health services. These community-based organizations act as the nation's health care safety net, delivering care tailored to the unique cultural needs of the neighborhoods and regions they serve, regardless of patients' ability to pay.

Despite the income levels of the patients they serve, well-managed health centers operate profitably and have shown over decades very low rates of loan default. The addition of new health care services and growth in the Medicaid-eligible population has led to a need for expanded facilities and financing tailored to the needs of these organizations. These vital expansions present opportunities for banks and other financial institutions to address those needs. Indeed, a recent survey<sup>12</sup> of health centers indicates plans for more than 1,000 new projects totaling in excess of \$7 billion over the next five years.

## Market Outlook

Health centers rely on a combination of federal and state grants, Medicaid



Capital Impact Partners

**Family Healthcare of Hagerstown, Md., has a newly renovated 33,000-square-foot primary care, dental, and mental health facility.**

and Medicare reimbursement, direct patient fees, private insurance payments, and fundraising to provide care. This funding requires health centers to provide cost-effective care but enables annual operating surpluses. Although funding comes from a variety of sources, two (Medicaid and a federal grant) provide the bulk of health center revenues, and continuation and growth of that funding will fuel expansion.

A typical health center receives a federal section 330 grant, representing 30 percent of its total annual revenues, that is designed to offset the cost of care to the uninsured. The section 330 grant funding has been consistent over past decades and recently was reaffirmed through strong bipartisan congressional support extending the funding through 2017. Additionally, the Affordable Care Act (ACA) has made millions of previously uninsured individuals eligible for Medicaid coverage, which has dramatically increased the number of

patients served by health centers.

Health centers now serve annually more than 5 million additional patients than they did at the advent of the ACA in 2010, and they are projected to serve at least 6 million more by the end of 2018. Health centers may achieve this level of growth only by expanding their facilities.

## Financing Challenges

Despite consistency of primary funding and increasing patient growth, now, as always, community health centers face many challenges in providing high-quality primary care to low-income patients. Growing demand for services places pressure on providers and facilities. State budget pressures have led to reductions in entitlement programs and services not covered by federal grants and Medicaid reimbursement. Organizations find it difficult to recruit and retain staff willing to work for lower wages in older facilities. Competitive pressures

<sup>12</sup> *Capital Plans and Needs of Health Centers, a National Perspective*, Capital Link, 2012.

## New Markets Tax Credits Leverage Health Center Expansion

Scott Sporte, Chief Lending Officer, Capital Impact Partners

Family Healthcare of Hagerstown, Md., (formerly Walnut St. Community Health Center), provides primary care and dental and mental health services to 7,000 patients each year, virtually all of whom live at or below 200 percent of the federal poverty level. Demand for services in the Hagerstown community is high, so the health center undertook a \$7.22 million New Markets Tax Credits (NMTC) transaction to allow it to move from a cramped 8,000-square-foot facility to a newly renovated 33,000-square-foot space.

Columbia Bank served as the senior lender for this transaction with a \$4.75 million loan through the NMTC structure. Columbia Bank also served as the NMTC investor, purchasing the tax credits to offset the bank's federal tax exposure. The funds exchanged for the tax credits were applied to the project, providing \$2.3 million in equity that the health center will not have to repay. Through the structure, the health center financed a \$7.7 million project budget with only \$4.75 million in debt (see table 1) that will need to be refinanced at the end of the transaction's seven-year term. The debt and equity provided by Columbia Bank made this important economic development transaction possible.

This loan will allow the health center to expand health care access in this federally designated Medically Underserved Area by doubling its patient base and opening an in-house pharmacy to provide low-cost



Capital Impact Partners

**Free health screenings, food, children's activities, fitness demonstrations, and tours of Family Healthcare of Hagerstown's new offices were part of the 2015 Healthy Families Festival.**

prescription medicine. In addition to the increased quality in primary care the health center will provide, the project will create an estimated 125 construction jobs and more than 25 full-time jobs.

For more information, e-mail Scott Sporte at [ssporte@capitalimpact.org](mailto:ssporte@capitalimpact.org).

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**Table 1: Sources and Uses for Financing Family Healthcare of Hagerstown**

Source	Amount
Bank & CDFI loan	\$4,752,797
Tax credit equity	\$2,322,803
State equipment grants	\$660,000
Health center equity	\$26,099
<b>Total sources</b>	<b>\$7,761,699</b>

Use	Amount
Acquisition	\$929,373
Renovation costs	\$4,417,746
Furniture, fixtures, and equipment	\$1,233,462
Soft costs and consulting fees	\$252,680
Contingencies	\$544,885
Debt service reserves	\$383,553
<b>Total sources</b>	<b>\$7,761,699</b>

are emerging from small urgent-care clinics in grocery stores and shopping centers. In addition to rising costs, shifting reimbursement streams, and the strain of a constantly growing demand for their services, health centers have traditionally encountered difficulty in obtaining appropriately structured financing for working capital, building projects, and equipment needs. This funding shortfall often exists because of a perception that the health centers' clientele, funding, and location make them higher-than-average risks.

Fortunately, experience has shown that community health centers and other community-based health care providers are remarkably resilient and resourceful. A recent survey of health centers administered by Capital Link, a nonprofit technical assistance provider to community health centers nationwide working with the Citi Foundation, found that health centers have been and are increasingly becoming more financially stable. The survey, conducted with information collected from health centers nationwide for fiscal years 2008 to 2011, uses several financial measures to determine an organization's financial condition, including liquidity, debt capacity, and profitability.<sup>13</sup>

Overall, the survey results demonstrate a group of organizations that are in line with traditional financial benchmarks and substantiate that many health centers nationwide present an acceptable credit risk for lenders and investors.

Health centers often suffer from the perception that they are providers of last resort, because they are

thought to have outdated facilities, unsophisticated systems, and higher-than-average credit risk. One national lender has, however, proven that health centers are a good credit risk and has made them the core of its lending activity. For more than 30 years, Capital Impact Partners, known until 2014 as NCB Capital Impact, has worked with community-based health care providers to fill the gap of financial knowledge and need and to provide assistance and offer a variety of appropriately structured loan products to finance working capital, facility acquisition, expansion and renovation, and new equipment purchases.

Capital Impact Partners is a community development financial institution (CDFI). As a mission-driven lender, Capital Impact Partners uses its tools of financing, technical assistance, and policy engagement to improve access to health care, education, housing, and healthy foods in underserved areas around the country. Because it is a mission-driven lender focused on social impact outcomes, Capital Impact Partners is often willing to provide loans to health centers that traditional banks shy away from.

With financing from Capital Impact Partners, health centers in many parts of the United States have demonstrated that they are a low investment risk, while improving their facilities' efficiency, expanding capacity, and maintaining a high quality of care for their patients. Over three decades, Capital Impact Partners has provided more than \$750 million in debt to over 500 health centers in 24 states. Together,

these health centers serve over 2 million patients annually.

Capital Impact Partners often works in partnership with public and private organizations to build loan funds that help create attractive financing options for health centers. Examples of creative financing partnerships are Capital Impact Partners' long-term relationships with the California Primary Care Association to create the CPCA Ventures Loan Program and the California Endowment to launch the Healthier California Fund. As a result of its work in California, Capital Impact Partners has provided financing to over 50 percent of health centers and clinics in the state.

This national portfolio has performed very well, with delinquencies averaging less than 0.5 percent per year and total losses of less than 0.1 percent.

A recent example of the type of project commonly financed by Capital Impact Partners is the South of Market Health Center (SMHC) in San Francisco, Calif. SMHC desired to construct a new facility and move from cramped rented space. SMHC's board and management wanted to construct a building that would be a focal point for their community but wouldn't, in their own words, "look like a clinic for poor people." For this project, a \$4 million construction and permanent loan from Capital Impact Partners augmented the clinic's \$500,000 capital campaign to make the new building a reality. Capital Impact Partners worked closely with management to structure payments anticipating improved cash flow after an initial ramp-up period. The

<sup>13</sup> *Community Health Center Financial Perspectives, Issue 1: Financial and Operational Ratios and Trends of Community Health Centers, 2008–2011: A Guide for Health Centers*, Capital Link and Community Health Center Capital Fund, August 2013.

## Lease to Ownership Leads to More Patient Coverage

Scott Sporte, Chief Lending Officer, Capital Impact Partners

Community Health Centers of the Central Coast (CHCCC) is a nonprofit corporation comprising nine community health centers providing quality medical, dental, and mental health services along California's central coast area, stretching from Santa Maria in the south to San Luis Obispo in the north.

CHCCC clinics serve more than 85,200 patients, and nearly 70 percent of those patients live below the federal poverty line. CHCCC worked with Beneficial State Bank and Capital Impact Partners, a community development financial institution (CDFI), to purchase a facility it had long been leasing. The terms of the debt saved CHCCC more than \$20,000 in lease expenses annually, enabling it to provide access to health services for even more patients. The sources and uses table (table 2) below gives the financial picture for the project.

The bank and CDFI partnership was structured as a participation, with the CDFI providing a small subordinate loan for some minor rehabilitation to the building.



Capital Impact Partners

Community Health Centers of the Central Coast marked National Health Center Week 2015 with the grand opening of its new Del Valle clinic as part of a weeklong campaign to raise awareness about the mission and accomplishments of this primary health care clinic.

For more information, e-mail Scott Sporte at [ssporte@capitalimpact.org](mailto:ssporte@capitalimpact.org).

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**Table 2: Financial Sources and Uses for Community Health Centers of the Central Coast**

Source	Amount
Bank loan	\$1,101,042
CDFI loan	\$1,335,043
Health center equity	\$39,000
<b>Total sources</b>	<b>\$2,475,085</b>

Use	Amount
Acquisition loan	\$2,251,085
Building improvements	\$224,000
<b>Total sources</b>	<b>\$2,475,085</b>

results matched expectations.

### Approaches to Health Center Financing

As health centers expand, so does the need for financing options. Fortunately, with organizations like Capital Impact Partners as a model, the job of educating lenders about community health centers and the unique financial opportunities and challenges they face has become less difficult.

Although community health centers face many concerns in providing care to low-income individuals, the challenge of facilities development is not insurmountable. Community health centers are essential community resources with a real need for financing capital expansion to meet growing health care needs. It is essential that lenders view community health centers as vital resources and seriously consider them as viable borrowers. Ways to minimize a lender's transaction

risk include pooling of resources and sharing transactions with other institutions, as described in the article on the CDFI Fund and Opportunity Finance Network (see page 8).

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# Leveraging Nontraditional Alliances

Kevin Boes, President and Chief Executive Officer, New Markets Support Company, Local Initiatives Support Corporation

**C**rippling rates of chronic disease continue to rise in low-income communities—even those that have benefited from investments in good housing, health facilities, jobs, and community safety. Lack of affordable health insurance for low-income families pushes them to seek care at hospital emergency rooms because preventive and primary care are unreachable.

What can we do to more explicitly connect community development to health services in ways that break the link between poverty and poor health?

That question brought together the Local Initiatives Support Corporation (LISC), Morgan Stanley, and the Kresge Foundation (Kresge) to launch the Healthy Futures Fund: an investment vehicle designed to connect health services and affordable housing projects. The Healthy Futures Fund brings these three partners together with a creative, shared vision for a new finance tool.

Thus far, the Healthy Futures Fund has proven to offer a compelling case for both health and community development by integrating multiple financial tools. It provides a mechanism to finance affordable housing by investing equity in Low-Income Housing Tax Credit (LIHTC) projects. It supports new community health centers with equity investments in New Markets Tax Credit (NMTC) transactions. It provides predevelopment grants and loans to advance both types of projects. And it offers grants that promote cross-sector collaborations



Local Initiatives Support Corporation

**The Healthy Futures Fund helped finance the expansion in Washington, D.C., of So Others May Eat (SOME), which will include a health center, affordable housing, a job-training center, and retail space.**

to make health and housing part of the same whole.

What's more, the Healthy Futures Fund structures transactions so that the process is replicable, minimizes repeated documentation, and limits the third-party support necessary to close transactions. This process makes these deals less expensive, even though they are often more complex than a traditional development project.

The result? Our initial \$100 million Healthy Futures Fund is fully deployed, and we are expanding with an additional \$100 million in new capital for 2016. Since our launch, we have signed on more than seven supporting partners to diversify our resources and expertise. And we are creating new on-the-ground connections that are slowly making housing and health care part of a common community development mindset.

It hasn't all been smooth sailing, of course. We learned early on that aligning the interests of housing

developers with primary care providers was easier said than done. While both types of organizations have long served a common client base, the two have not typically worked together. They are driven by a different line-up of policies and unique funding streams that often create a fragmented approach. The Healthy Futures Fund offers the tools and partners to bring those pieces together.

That disconnect was pretty clear when the Healthy Futures Fund partners looked at a proposed affordable housing deal in the East Side community of St. Paul, Minn. Lutheran Social Services of Minnesota and the West Side Community Health Services (WSCHS) were both working in the area to meet the needs of low-income households. Yet they didn't really know of each other. Lutheran Social Services focused on developing affordable housing to ensure residents had quality apartments they could afford. WSCHS was expanding its

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health care services through the development of its East Side Family Clinic. They were operating on parallel tracks but had little reason to intersect. LISC, which has long worked in the same neighborhood and had deep connections there, proved to be the common thread.

When Lutheran Social Services leaders approached LISC with their plan to rehabilitate the 108-unit Rolling Hills Apartments to serve low-income refugee families, we brought WSCHS and its health care delivery expertise to the table to work on ways to integrate health services into the development process. The Healthy Futures Fund invested more than \$10 million in LIHTC equity to support the revitalized housing and also provided a grant to build out space for on-site health examinations as part of the rehabilitation effort. Now WSCHS is delivering preventive health care and health education for the housing residents and the surrounding community.

The Healthy Futures Fund contributed additional grant dollars so the two providers could do the research they needed to be thoughtful in their approach. WSCHS conducted a series of community needs assessments that brought them closer to residents and facilitated their understanding of the services needed. All told, the effort did more than join health care and housing for the benefit of low-income residents. The effort also helped stabilize refugee families and created a more cohesive community that would help support them as they acclimate into American life and economic stability.

Like so much of LISC's community development experience over the

last 35 years, Rolling Hills proved to be a convincing case in point. Success in community development often hinges on strong partnerships among public, private, nonprofit, and philanthropic organizations that reach beyond traditional approaches to solve deep-seated problems. It takes a good deal of creativity and expertise to have a sustainable impact. And it takes a good deal of long-term capital as well.

That's why, in addition to LISC, Kresge, and Morgan Stanley, the Healthy Futures Fund has been adding additional community development finance partners to help. All of the new partners bring multiple assets to the table, especially their deep passion and experience in community development components, such as housing and health care, and the federal programs that help fuel them.

Notably, many of our partners are contributing portions of their NMTC allocations to the effort. The tax credits are part of \$3.5 billion in annual investment authority from the U.S. Department of the Treasury's Community Development Financial Institutions Fund to encourage commercial redevelopment in low-income communities. In many respects, the NMTC Program is a companion community development tool to the LIHTC Program: one promotes housing development for low-income people, and the other focuses on attracting businesses and community facilities to low-income neighborhoods.

This alignment of partners and programs is critical because the Healthy Futures Fund's deals do not generally come together like most community development projects. These projects depend

on new alliances that have to be nurtured, both from an investment perspective and an operational one. For example, in Brockton, Mass., the Healthy Futures Fund supported a new community health center that is co-located with a new grocery store, with the partners jointly redeveloping a blighted commercial corner that has dragged down the surrounding area. The partnership is, however, about much more than real estate development. It quite intentionally pairs a health provider with a food provider in an effort to help low-income people eat better and live longer. The two are working together to offer nutrition programming, advice on shopping for healthy food, and cooking classes—all focused on reducing diabetes, obesity, and a range of other conditions.

Technically, the Brockton plan is structured as two different deals, one to finance the health center and a second for the grocery store. Brockton Neighborhood Health Center developed the 14,000-square-foot clinic, with \$8.4 million from the Healthy Futures Fund, including capital contributions from LISC, Morgan Stanley, Kresge, and Opportunity Finance Network. LISC also financed the grocery store, with \$3 million in low-cost loan capital.

How does all of that connect to affordable housing? The health center is collaborating with local housing providers on a series of outreach and education programs around chronic disease management, funded in part with Healthy Futures Fund grants. Under normal circumstances, little impetus exists for a grocer, health care provider, and housing organization to join forces. But this partnership effort



## Catalyzing the Investment

Kimberlee Cornett, Managing Director, Social Investment Practice, the Kresge Foundation

Whether we realize it or not, community developers also need to be in the health business. Housing developers and community health care providers are both working to alleviate the many facets of blight so that distressed areas can become stable neighborhoods where residents have a better chance to live well. The Kresge Foundation believes that together, housing developers and community health care providers can accomplish more.

In the United States today, 41 million<sup>14</sup> individuals lack health insurance, and \$38 billion a year<sup>15</sup> is wasted on unnecessary visits to hospital emergency rooms for care that could be provided by a more cost-effective health center. If we want to see low-income communities thrive, key strategies for health care, housing, and other community needs, like healthy food access and quality education, should be integrated with financing considerations from the outset.

Three organizations, the Local Initiatives Support Corporation (LISC), Morgan Stanley, and the Kresge Foundation (Kresge) have come together and launched the Healthy Futures Fund—a one-of-a-kind investment vehicle that directly connects health services to residents of affordable housing projects.

The Healthy Futures Fund is not the first time the founding partners have worked together, nor is it their first foray into the social determinants of health. But the Healthy Futures Fund differs from other efforts. What



Local Initiative Support Corporation

### **The Healthy Futures Fund partnered with the Brockton Neighborhood Health Center and Vicente's Tropical Grocery in Brockton, Mass.**

started out as a brainstorming session between the three principals morphed into a shared strategy that takes a community development approach to health. The Healthy Futures Fund is a new vehicle to do that.

To meet the challenges, LISC, Kresge, and Morgan Stanley formed the \$100 million Healthy Futures Fund in late 2012 to support the growth of high-quality, community-based federally qualified health centers (health centers) that are linked with affordable housing. The Healthy Futures Fund addresses the cross-sector needs of communities by searching for opportunities to locate health care facilities with or near affordable housing and by generating collaborations that can maximize the impact of both the philanthropic and the investment dollars that are involved.

illustrates one of the Healthy Futures Fund's key goals: to help build nontraditional alliances that bring lasting gains to neighborhoods.

Another rationale for the Healthy Futures Fund centers on the Affordable Care Act, more commonly known as Obamacare. The law earmarks funding for more health centers, especially in disadvantaged areas. It also created millions of newly insured residents eager to take advantage of consistent

access to primary care—in the case of many low-income families, for the first time ever.

After the law was passed the Healthy Futures Fund partners wanted to support health center expansion to meet growing demand. Disadvantaged areas are particularly evident in rural America, where so many areas are medically underserved. The first health center deal the Healthy Futures Fund closed was in the small town of Omak,

Wash., where approximately 34 percent of the population lives below the poverty line. A local provider, Family Health Centers, wanted to relocate and expand its clinic to better reach residents. With \$6.6 million in Healthy Futures Fund financing, made possible by NMTCs from the National Development Council, the provider nearly quadrupled the size of the medical clinic and doubled the size of its pharmacy. It can now accommodate more than 70,000 patient visits a year.

<sup>14</sup> "Gallup: More Willing to Defy ObamaCare Rule," *The Hill*, November 13, 2014.

<sup>15</sup> "Avoiding Emergency Rooms," *The New York Times*, April 15, 2013.

The Healthy Futures Fund operates on the simple premise that better access to primary care services can have a direct and positive impact on an individual's health status. In creating the Healthy Futures Fund, the three organizations also sought to influence the direction of investing for the community development industry as a whole, making it both more holistic and more efficient—basically to achieve greater impact without greater cost.

Investing alongside LISC and Morgan Stanley gave Kresge a way to leverage its funds with other capital to create exponentially more investment and impact. Today, the Healthy Futures Fund is fully invested in five health centers, providing health care to over 96,000 people and creating 418 units of new affordable housing.

The initial \$100 million Healthy Futures Fund has been so successful that the partners are capitalizing a second round. This second wave of \$100 million will finance affordable housing development, community health centers, and local services that address the social determinants of health in high-poverty areas.

To strengthen the new Healthy Futures Fund, a team of nonprofit partners, with health and housing expertise and financial resources, has been added to the collaboration. These partners include Capital Impact Partners, Capital Link, Corporation for Supportive Housing, Dignity Health, Mercy Loan Fund, National Development Council, Opportunity Finance Network, and Primary Care Development Corporation.

From the first Healthy Futures Fund, several examples have emerged of organizations taking on ambitious projects and partnerships to improve health conditions through community development:

In Washington, D.C., the nonprofit organization So Others Might Eat (SOME) is building a co-located health center and housing project in a marginalized, low-income neighborhood, conveniently located near public transit. The project will also contain a job-training center and retail space.

In Brockton, Mass., Brockton Neighborhood Health Center and Vicente's Tropical Grocery collaborated to construct a health clinic and a healthy and culturally relevant food market for the community.

As Kresge, Morgan Stanley, and LISC discuss the next chapter of the Healthy Futures Fund, its partners see a new class of health centers emerging that will both provide health services and help shape external conditions—the social determinants of health—often at the root of medical problems that bring people to the doctor. Identifying and bringing to market the kinds of capital that accelerate this mutually beneficial type of development are the next steps for the Healthy Futures Fund.

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On its own, the new facility is a much-needed local resource. But the Healthy Futures Fund partners also wanted to more directly connect it to low-income housing residents. That's why the Healthy Futures Fund provided grant dollars for the purchase of transportation vouchers. The vouchers will help area residents overcome a major barrier to care in rural communities: ready access to personal or public transportation.

With each deal, we cement more partnerships and gain more experience. From Menominee,

Mich., and Muncie, Ind., where the Healthy Futures Fund has supported new housing with on-site health care, to Toledo, Ohio, and Raleigh, N.C., where we are funding new health centers that extend services to nearby housing developments, the Healthy Futures Fund partners are focused on innovative ways to improve the quality of life for people who struggle to make ends meet.

LISC has always been a bridge, bringing technical assistance and financing to support the dreams of its community development

partners and create lasting physical assets in distressed communities. Now, with the various tools of the Healthy Futures Fund, we are more intentionally connecting community development to health care in ways that will have a lasting impact on the communities where we work.

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# Collaboratively Financing Healthy Futures

Lindy Hahn, Executive Director, Morgan Stanley

The combination of affordable housing and access to health care has powerful potential to transform the lives of families and individuals. Residents need access to health and dental care providers, in addition to other social services, to improve their well-being and economic resilience. Numerous studies have demonstrated the link between poverty and health, including a key finding that the single biggest determinant of health is not a person's genetic code, but his or her zip code.<sup>16</sup>

In 2013, Local Initiatives Support Corporation (LISC), the Kresge Foundation (Kresge), and Morgan Stanley partnered to form the Healthy Futures Fund to support the growth of high-quality, community-based health centers linked with affordable housing. The Healthy Futures Fund helps realize opportunities to locate health care facilities with or near affordable housing. Based on the success of the original Healthy Futures Fund, an expansion was announced in late 2015, doubling the original \$100 million commitment.

The Healthy Futures Fund requires the right combination of distinct yet collaborative partners to achieve its intended impact. We rely on our partners to make the Healthy Futures Fund possible through their great experience and skills, deep understanding of their communities and issues, and grant and risk capital. Together, Kresge, LISC,



Morgan Stanley

**Omak Medical Clinic and Pharmacy is part of the Family Health Centers of Okanogan, Wash., which received funding from the Healthy Futures Fund.**

and Morgan Stanley provide the community development expertise, local on-the-ground knowledge, and capital needed to bring health services to underserved communities. Each partner in the Healthy Futures Fund plays a unique role in identifying and allocating resources to needed projects.

Kresge, with a mission to expand opportunities in underserved communities across the nation, provided most of the up-front, at-risk capital to the Healthy Futures Fund, along with grants for technical assistance to help ensure success. Kresge provided \$7 million of the lending capital for the Healthy Futures Fund, which is being managed by New Markets Support Company (NMSC), a wholly owned subsidiary of LISC. Kresge is also providing up to \$1.5 million of grant

capital to fund technical assistance to health centers.

LISC, through a coordinated local and national effort, identifies and promotes community development project opportunities and administers the grants and loans to projects and their sponsors. Both LISC's National Equity Fund (NEF) affiliate and NMSC subsidiary find opportunities and manage underwriting for the Healthy Futures Fund.

Whereas NEF supports housing developments through housing tax credit investments, NMSC supports health center financing through an innovative debt-equity product. As the underwriter, LISC facilitates the transactions, and where needed, provides subordinated debt or grant dollars to help close funding gaps on a particular project.

<sup>16</sup> Robert Wood Johnson Foundation, *Beyond Health Care: New Directions to a Healthier America*.

Morgan Stanley, as the private sector investor, has provided the Healthy Futures Fund up to \$32 million of debt for New Markets Tax Credit (NMTC) transactions, \$17 million of NMTC equity to be leveraged with New Markets loans, and a \$54 million housing tax credit equity fund managed by NEF. This \$54 million Low-Income Housing Tax Credit (LIHTC) equity commitment allows project sponsors a portion of LIHTC equity to be used for health care programming aligned with the goals of the fund.

The Healthy Futures Fund partners also leverage the involvement of federal resources and programs. Both the LIHTC and NMTC programs make critical components of the Healthy Futures Fund possible. Public sector capital, such as the federal grants provided by the U.S. Department of Health and Human Services, delivers project equity capital and also acts as an affirmative endorsement of project operators. In an environment when some government programs are being reduced or eliminated altogether, maximizing the potential of government support remains a significant element necessary for the Healthy Futures Fund's success.

This layering of capital sources, together with the strong teamwork within the fund, provided Morgan Stanley with the necessary risk mitigation to participate. Traditionally, in new financing solutions, such as the Healthy Futures Fund, market needs cannot be determined with complete certainty until the model

is activated in the marketplace, creating exposure to risk. The distinct but connected pieces of the Healthy Futures Fund provide the flexibility to accommodate new or unanticipated considerations and at the same time offer the discipline to help assuage concerns of the capital providers.

Today, the Healthy Futures Fund is fully invested in five health centers, providing health care to more than 50,000 people and creating 418 units of new, affordable housing. For example, a Washington state project used a \$6.6 million loan from the Healthy Futures Fund to finance the construction of a new health clinic for Family Health Centers (FHC), a well-established local health care provider. The clinic expansion more than doubled the number of examination and procedure rooms; the FHC system expects it will expand capacity to serve more than 70,000 patient visits per year by 2017. FHC is a necessary resource in the area, serving more than 30 percent of the residents of Okanogan County, Wash.,<sup>17</sup> where poverty is nearly double the statewide rate.<sup>18</sup>

What sets the execution of the Healthy Futures Fund apart from other NMTC endeavors is the flexibility and efficiency of the structure; savings in formation legal costs; and enhanced likelihood of refinancing at the end of the seven-year compliance period. Morgan Stanley, Kresge, LISC, and LISC's NMSC subsidiary are dedicated to providing efficient capital to health centers and incorporating healthcare

more fully into affordable housing activities. LISC and Kresge have determined that many health centers require a comprehensive capital response, that is, a package of technical assistance and one or more forms of capital. With LISC and Kresge, we are uniquely positioned to provide these resources because of our teamwork and collective lending and equity expertise. Together as fund collaborators, we are creating financing resources available for health centers in target underserved markets across the country.

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<sup>17</sup> Health Resources and Services Administration, 2014 Health Center Profile, Family Health Centers, Okanogan, Wash.

<sup>18</sup> U.S. Census Bureau, QuickFacts, Okanogan County, Wash.

# Beneficial Partnerships, Missions, and Values

Kevin Goldsmith, Senior Vice President, Community Development Banking, New Markets Tax Credit Group, JPMorgan Chase Bank, N.A.

Federally qualified health centers (FQHC or health center) have been serving low-income communities for 50 years and have become the backbone for delivering primary care to more than 20 million low-income and uninsured Americans. Through a combination of federal New Markets Tax Credits (NMTC) partnerships with community development financial institutions (CDFI) and working with the U.S. Department of Health and Human Services, banks can play a meaningful role helping FQHCs expand and grow their operations. This is exactly what JPMorgan Chase Bank, N.A. (Chase) has been doing.

Since 2009, Chase has invested \$119 million of NMTC equity in 32 FQHC projects, leading to a total of \$378 million in qualified equity investments (QEI). These investments have leveraged additional direct investment in the projects outside of the NMTC structure, resulting in a total development cost of over \$550 million.

In 2014 alone, Chase provided \$24 million of NMTC equity into six health center projects, resulting in total QEIs of \$74 million and total development costs of \$146.6 million. These six projects provided access to health care for 325,000 individuals and brought a significant number of full-time equivalent jobs to low-income communities.



Chase

**Asian Health Services in Oakland, Calif., was collaboratively financed by Enterprise Community Partners, JPMorgan Chase, and the Nonprofit Finance Fund.**

Additionally, Chase New Markets Corporation, the community development entity controlled by Chase, provided \$14 million of allocated NMTCs to another six projects between 2009 and 2013. Chase partnered with 24 other community development entities to secure NMTC allocations for the remaining \$364 million in QEIs.

Behind these numbers lies a mutually beneficial partnership between multiple public and private institutions, driven by a strong alignment in missions and core values.

The Health Resources and Services Administration (HRSA) is the primary federal funding agency

for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. Recently, the availability of Medicaid for eligible recipients was significantly expanded by the Affordable Care Act (ACA).<sup>19</sup> But a significant shortfall remains in delivery of medical services to underserved populations because of an existing shortage of physicians and other medical team members. Moreover, this personnel shortage has been exacerbated by the spike in demand from increased availability of Medicaid coverage.

HRSA seeks to improve access, quality, and equity of care through funding directed to health centers

<sup>19</sup> The ACA actually refers to two separate pieces of legislation—the Patient Protection and Affordable Care Act (PL 111-148) and the Health Care and Education Reconciliation Act of 2010 (PL 111-152)—that together expand Medicaid coverage to millions of low-income Americans and make numerous improvements to both Medicaid and the Children’s Health Insurance Program.

for the provision of essential primary and preventive health care services. The services target low-income underserved populations and communities. Ultimately, both HRSA and health centers are working to improve the quality of life for low-income families and individuals by providing better and more economical health care and more jobs to support community economic development.

These goals are strongly aligned with the mission of community development banking at Chase, many CDFIs, and the CDFI Fund, and, ultimately, are the purpose of the NMTC program.

Naturally, the opportunity for partnership arises from these well-aligned intentions. Moreover, a need is clearly evident for growth and expansion of the health center program, creating a sense of urgency among those parties prepared to take action. This collaborative environment has been critical to Chase's ability to overcome obstacles facing the expansion of the health center program and to execute successful NMTC transactions for the financing of health centers.

Chase is dedicated to economic and community development across the firm's footprint. Providing solutions to the health care challenges our country faces is a critical component of pursuing that mission. Furthermore, the NMTC program emphasizes community impact, the assessed need for better access to community facilities, and delivering tangible benefits for low-income communities. Additionally, to receive operating grant funds

from HRSA, health centers must meet HRSA requirements.<sup>20</sup> These community-supporting requirements are the central reason why Chase believes that health centers are ideal candidates for NMTC financing.

Most traditional lenders face significant challenges when considering the decision to extend credit to health center projects. Fortunately, Chase's NMTC group has developed sufficient flexibility and expertise through partnerships and experience and can successfully manage many of these challenges. Most traditional lenders look to cash flow from operations as the source of their principal repayment. But Chase has learned that this is a metric by which most health centers appear weak and non-creditworthy.

Health centers are required to serve low-income and uninsured individuals via a sliding fee scale and are often located in communities with unstable, struggling economies. Health centers receive very limited revenue from "traditional customers," as patients frequently pay only what they are able to, which is often nothing. Although the sliding fee scale is a critical component for serving the mission, from a community impact perspective many lenders are not comfortable with this financial profile. In the past, this has significantly inhibited access to traditional financing for health centers.

Health centers do not necessarily lack adequate revenue, however; it is merely coming from a different source. Understanding health centers' business model is critical to

developing confidence in extending credit to them. Through Chase's experience in financing health centers under the NMTC program, we have developed confidence that these organizations are significantly supported by the resources and creditworthiness of the federal government. By definition, health centers receive grants from HRSA under section 330 of the Public Health Service Act to fund operating deficits, and qualify for enhanced reimbursement from Medicare and Medicaid programs. Although health centers themselves are not large institutions with investment-grade credit ratings, they are sustained by the quintessential large and creditworthy institution: the U.S. government.

NMTC program regulations and health center program regulations have not, however, always been compatible. Opening a line of communication between HRSA, Chase, and strong CDFI partners has enabled the parties to identify common goals between programs. Ultimately, the recognition of common goals has enabled the reconciliation of regulatory issues that prevented Chase from using grant funding from HRSA as NMTC leverage. Frequently, these grants came through construction expenditure reimbursements, which required the funds to be bridged. This provided Chase and many of its CDFI partners with opportunities to experience important nuances of the credit relationship with health centers, without requiring Chase to take on the risk of a traditional cash flow loan. Moreover, the communication experience with

<sup>20</sup> HRSA requirements include the following: Serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors that includes community members.

## Federally Qualified Health Center Spotlight: Erie HealthReach Waukegan Health Center, Waukegan, Ill.

*Kevin Goldsmith, Senior Vice President, Community Development Banking, New Markets Tax Credit Group, JPMorgan Chase Bank, N.A.*

A \$9.25 million New Markets Tax Credit (NMTC) transaction provided critical financing for the acquisition and rehabilitation of a former bank building in Waukegan, Ill. The building is now used as a comprehensive health center facility, complete with medical, dental, behavioral, and mental health services and examination rooms.

ESIC New Markets Partners LP, with the cost of equity controlled by Enterprise Community Partners, a national community development financial institution, provided all of the NMTC allocation for the project, as well as a \$2.4 million term loan and a \$1.9 million loan to bridge a portion of a \$4 million Health Resources and Services Administration grant. JPMorgan Chase provided a \$3.03 million NMTC equity investment for the structure.

The Lake County Health Department estimates that Erie HealthReach Waukegan Health Center's (Erie) proposed Greater Waukegan service area is home to over 90,000 medically underserved residents, many of whom are uninsured or Medicaid enrollees. Of these 90,000 underserved residents, just 32 percent are currently served by the safety net providers operating in Lake County, Ill. Effectively two-thirds of all medically underserved residents in Greater Waukegan have no access to affordable health care. The new Waukegan health center clinic will leverage Erie's decades of experience and unmatched capacity for serving low-income immigrant patients in a dramatically underserved community.

With the addition of the health center, Erie will be able to accommodate up to 42,000 patient visits per year,



Source: Chase

**The new Erie Healthcare Center in Waukegan, Ill., received a \$3.03 million New Markets Tax Credit equity investment from JPMorgan Chase Bank NA.**

including 30,000 medical visits and 12,000 dental or oral health visits. These services are expected to reach 14,000 unique patients, of whom 89 percent are anticipated to have incomes at or below 200 percent of the poverty line, and 35 percent are expected to be uninsured. The facility's location, in close proximity to public transit, will further broaden its reach to low-income residents. Additionally, the project is estimated to create 32 full-time health care positions by 2017.

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HRSA and frequent activity in closing NMTC financing for these projects enabled the collaborative to advise the health center management and helped improve communication with HRSA. Improved communication ensured the project's success and the repayment of bridge financing.

Arriving at a mutually beneficial resolution with HRSA was a critical accomplishment, since HRSA grants have frequently served as the lion's share of the NMTC leverage loan, providing adequate "soft" funding to appropriately capitalize a health center NMTC transaction. HRSA grants are often about \$5 million.

When NMTC equity is added to the capital stack and combined with funds from HRSA, leverage, debt service coverage, and other financial risk metrics are very favorably affected. For example, in a \$10 million QEI scenario, the remaining leverage gap is likely approximately \$2 million. CDFI

lenders bring knowledge and expertise of health centers as an asset class and strong familiarity with local communities. These qualities reduce the leverage gaps and provide traditional lenders with increased confidence. With partners in place, the lender can extend the final piece of leverage to health centers via traditional credit, helping a transaction get over the finish line.

After initially closing NMTC transactions on a one-off basis, Chase and two of its strongest nationally focused CDFI partners, Enterprise and the National Equity Fund, formed a strategic collaboration to provide “one-stop” NMTC financing for health centers. These two CDFIs provide the debt and NMTC allocation, and Chase provides the NMTC equity. The collaboration allows the NMTC investments of the three parties to maximize community impact.

To further maximize impact, we wanted to reduce the general difficulty of obtaining leverage loans for any NMTC project. We also wanted to comply with the aforementioned HRSA guidance allowing grants to be leveraged using construction-period bridge financing and to hold discussions between the three parties identifying a common interest in financing FQHCs. The ultimate goal of the collaboration is to develop expertise through a focus on FQHCs and bring down NMTC transaction costs by reducing the variety of financing sources and parties involved.

Doing so also requires enabling the use of “boilerplate” documents and consistent loan terms from the two CDFI lenders. Expected collaboration efficiencies could

reduce overall NMTC transactions costs by 10 percent to 20 percent, facilitating the use of NMTCs to serve many additional FQHC developments. This partnership remains critical to Chase’s success in financing FQHCs through NMTCs.

Additionally, Chase’s NMTC group is fortunate to be housed within a firm that has a broad and deep platform. Our firm employs bankers and credit professionals who specialize in covering health care, government, nonprofit, and CDFI clients. Leveraging their expertise, both on an industry-wide and individual relationship basis, has been critical to our success.

One recent trend we have noted, especially during the latter part of 2014, is that HRSA is starting to move away from providing capital grants for these expansion projects. This movement indicates that health centers have increased access to traditional financing, as more and more traditional lenders have a better understanding of what lending to a health center entails and are comfortable with the federal government representing a large portion of their source of repayment, especially given the expanded Medicaid coverage available under the ACA. This is a promising trend for the commercial viability of future health center financing, and Chase looks forward to developing new partnerships and strengthening existing ones to take further steps towards our collective goal.

Health centers are unique but not necessarily inherently risky. The resources and creditworthiness of the U.S. federal government significantly support health center

operations. Creditors are typically averse to going too far outside the box when their capital is at risk, but we at Chase are slowly starting to see that box expand to include health centers.

Health center financing typically fits very well into an NMTC scenario. HRSA capital grants have frequently provided adequate “soft” funding to appropriately capitalize a health center NMTC transaction. Since these grants are often funded as reimbursements, the historical requirement for lenders to bridge these soft funds has given them experience and added comfort in extending traditional credit. The nature of health center projects fits well within NMTC regulations and results in the positive community impact that all parties want.

There is an urgent and overwhelming demand for health care resources in the United States, and no single organization is capable of providing a solution on its own. Partnerships between public and private organizations, as well as between for-profit and nonprofit organizations, are crucial to take steps towards reaching a solution. Identifying common goals between these organizations is critical to fostering successful actions.

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# Federal Government Support: Guaranteed Loan Funds

The U.S. Department of Health and Human Services (HHS) and the U.S. Department of Agriculture actively support the growth and stability of health centers by offering funds, usually grants, and programs that guarantee bank loans to health care projects. These federal programs, when appropriated funds are available, can help banks interested in lending to creditworthy health centers. This article explains both programs.

## HHS Funding Sources for Health Center Facility Projects

*Health Resources and Services Administration Staff*

The Health Resources and Services Administration (HRSA) is an agency within HHS. HRSA works in a number of ways as the primary federal agency to improve health and achieve health equity through access to quality services, a skilled health workforce, and innovative programs. HRSA programs target people who are geographically isolated or economically or medically vulnerable.

HRSA manages a loan guarantee program administered by HHS's Bureau of Primary Health Care. Eligible applicants for the loan guarantee program fall into one of two categories: managed care plans or networks and facilities. For decades, health centers have had difficulty accessing capital funding at affordable lending rates and have experienced delays in obtaining available financing. The purpose of this loan guarantee program is to significantly lower the lending barriers to reduce unnecessary costs and increase access to capital for health centers funded through section 330 of the Public Health Service Act (42 USC 254[b]). The guarantee covers up to 90 percent of the loan principal. While this program has been very successful, limited funds and great demand have exhausted the program funding, and the program is presently not open for applications. Future funding is uncertain.

HRSA also funds national organizations that help health centers meet HRSA program requirements and improve performance for special populations, vulnerable populations, and underserved communities and populations.

### Affordable Care Act Funding

Health centers play a critical role in the nation's



Health Resources and Services Administration

**The Whittier Street Health Center, in Roxbury, Mass., was financed with a federal loan guarantee program.**

health system. These centers provide a vital source of primary care for uninsured, underinsured, and medically underserved patients seeking a quality source of care. To support this role, the Affordable Care Act established the Community Health Center Fund, which initially provided \$11 billion over a five-year period, from 2010 to 2015, for the operation, expansion, and construction of health centers throughout the nation. The first \$9.5 billion was targeted to support ongoing health center operations; creating new health center sites in medically underserved areas; and expanding preventive and primary health care services, including oral health, behavioral health, pharmacy services, and enabling services, at existing health center sites. The remaining \$1.5 billion supported major construction and renovation projects at community health centers nationwide. New funding for 2016, an additional \$100 million, will support improving and expanding

the delivery of substance abuse services provided by existing Health Center Program award recipients, and a projected \$150 million will support construction and renovation of health center service delivery sites. Together, these funds have strengthened the existing network for health care providers and patients.

The Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act of 2015 authorized and appropriated an additional \$3.6 billion annually in fiscal years 2016 and 2017 to extend the Community Health Center Fund. This money, administered by HRSA, has helped health centers prepare for the new health care landscape by building modern facilities, adding providers and services, providing care in new communities, increasing use of technology, and getting people into affordable insurance options.

### **Indian Health Service Funding**

According to HRSA’s Health Center Program description, “outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination Act or by an Indian organization receiving funds under title V of the Indian Health Care Improvement Act can become health centers by meeting program requirements and applying to HRSA for funding or look-alike status.”

Public entities, such as tribes, and private nonprofit organizations, such as tribal corporations that have a medically underserved area or population within their service areas, are eligible to apply for health center status provided they meet certain requirements, including the following:

- Serve a high-need community or population.
- Make services available to all, with fees adjusted

based upon ability to pay.

- Meet performance and accountability requirements regarding administrative, clinical, and financial operations.

HRSA is working with federal agency partners and tribal communities to improve access to health professionals, health centers, and affordable health care in hopes of reducing tribal health disparities.

HRSA and the Indian Health Service and tribal organizations work together to bring better, affordable, comprehensive, and culturally acceptable health care to American Indians and Alaska natives. The two agencies are natural partners in improving the lives of tribal populations.

For the past 50 years, health centers have delivered comprehensive, high-quality preventive and primary health care to patients regardless of their ability to pay. During that time, health centers have become the essential primary care medical home for millions of Americans, including some of the nation’s most vulnerable populations. Health centers also continue to be an integral source of local employment and economic growth.

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## USDA Community Facilities Guaranteed Loan Program

*Terence McGhee, Regional Coordinator, USDA Rural Development*

The U.S. Department of Agriculture (USDA) energetically works at investing in rural communities and families as a key lynchpin to the economic sustainability of rural America, and ultimately, the nation as a whole. As a leader and partner, USDA Rural Development realizes that the USDA can't do it alone and eagerly seeks partners in the private sector to join together in continued investment in rural America.

Rural Development, through its Community Facilities programs, has taken a leadership role in facilitating and strengthening public-private partnerships with capital credit markets and institutional investors. This effort is to ensure that rural residents have the opportunity for a brighter future with good schools, quality health care, and other critical community infrastructure needs.

The Community Facilities Guaranteed Loan Program is an important tool in the USDA toolbox to help stimulate private investment in rural America. This program provides loan guarantees to eligible private lenders to finance essential community facility projects in rural areas of 20,000 people or less. A working definition for an essential community facility is a facility that provides an essential service to the local community for the orderly development of the community in a primarily rural area and does not include private, commercial, or business undertakings. Eligible lenders for the Community Facilities Guaranteed Loan Program must be regulated by either a federal or state banking regulatory agency.

Eligible borrowers for Community Facilities loans include public body organizations, community-based nonprofit corporations, and federally recognized Indian tribes. Over 100 different types of essential community facilities can be financed through the Community Facilities Guaranteed Loan Program. Facilities range from health care facilities, such as federally qualified health centers, hospitals, medical clinics, dental clinics, nursing homes, and assisted living facilities, to public safety facilities, such as fire departments and police stations. These investments are meant to reshape rural America one community at a time.

The Community Facilities Guaranteed Loan Program establishes the terms of the guarantee, and the lender and the borrower negotiate the terms of the loan.



USDA

**The East Central Oklahoma Family Health Center in Wetumka, Okla., opened its doors on January 2, 2009, and later received financing guaranteed by the U.S. Department of Agriculture.**

Currently, there are nearly 670 guaranteed loans in the Community Facilities portfolio, with nearly 55 percent of these loans made for rural health care facilities. Since 2009, USDA Rural Development has guaranteed over \$770 million in loans to rural communities for financing health care facilities. One such loan, guaranteed by USDA RD Community Facilities Guaranteed Loan Program, was made by REI New Markets Investment, LLC, to the East Central Oklahoma Family Health Center in June 2010. The health center in Wetumka, Okla., used the \$1.9 million guaranteed loan to construct a new 11,000-square-foot facility that includes 12 examination rooms, medical offices, dental operating rooms, a health education room, and support offices.

From fiscal years 2012 to 2015, Community Facilities programs invested in 416 public-private partnership community infrastructure projects across rural America in 49 states. In addition, Community Facilities leveraged over \$2.7 billion in Community Facilities direct loan funds, with \$1.4 billion from institutional investors and the capital credit markets to strengthen investments in critical community infrastructure projects. These dollars spurred economic growth, job creation, and access to improved health care, education, and other critical services.

*For more information about how your lending institution can partner with USDA, please visit our website at [www.rd.usda.gov](http://www.rd.usda.gov) or e-mail Terence McGhee at [terence.mcghee@wdc.usda.gov](mailto:terence.mcghee@wdc.usda.gov).*

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# Resources

## Health Center Terminology

**Affordable Care Act (ACA):** The ACA provides Americans with better health security by putting in place comprehensive health insurance reforms that

- expand coverage,
- hold insurance companies accountable,
- lower health care costs,
- guarantee more choice, and
- enhance the quality of care for all Americans.

The ACA actually refers to two separate pieces of legislation—the Patient Protection and Affordable Care Act (PL 111-148) and the Health Care and Education Reconciliation Act of 2010 (PL 111-152)—that together expand Medicaid coverage to millions of low-income Americans and make numerous improvements to both Medicaid and the Children’s Health Insurance Program (CHIP).

**Children’s Health Insurance Program (CHIP):** CHIP provides health coverage to eligible children through both Medicaid and separate Children’s Health Insurance programs. CHIP is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.

**Community development financial institutions (CDFI):** CDFIs are private financial institutions dedicated to delivering responsible, affordable lending to low-income and underserved communities so that these communities can join the economic mainstream. CDFIs are mission-driven, meaning that they measure their success through nonfinancial as well as financial returns. The mission may be revitalizing a neighborhood; helping a specific population, such as immigrant women in poverty, become economically self-sufficient; or building certain assets, such as affordable housing, charter schools, or health care centers, to serve low-income and underserved communities.

**Community Health Center Fund:** The ACA established the Community Health Center Fund, which provided \$11 billion over a five-year period for

the operation, expansion, and construction of health centers.

**Cost-based reimbursement:** The provider is reimbursed according to actual allowable costs. Health centers that meet federal requirements are a class of Medicaid and Medicare providers entitled to 100 percent of reasonable costs.

**Enabling services:** Under section 330(b)(1)(A)(iv) of the Public Health Service Act (PHSA), enabling services are non-clinical services, not including direct patient services, that enable individuals to access health care and improve health outcomes. Enabling services include case management, referrals, translation/interpretation, transportation, eligibility assistance, health education, environmental health risk reduction, health literacy, and outreach.

**Enhanced reimbursement:** All organizations receiving grants under section 330 of the PHSA qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. Certain tribal organizations and health center look-alikes, organizations that meet PHSA section 330 eligibility requirements but do not receive grant funding, also may receive special Medicare and Medicaid reimbursement. These enhanced reimbursements reflect that health centers serve underserved areas or populations (as do some tribal organizations and look-alikes), including people who cannot pay.

**Essential community facility:** The U.S. Department of Agriculture’s community facility loan programs provide affordable funding to develop essential community facilities in rural areas. An essential community facility is a facility that provides an essential service to the local community for the orderly development of the community in a primarily rural area, and does not include private, commercial, or business undertakings.

Examples of essential community facilities include the following:

- Health care facilities, such as hospitals, medical clinics, dental clinics, nursing homes, or assisted living facilities.

- Public facilities, such as town halls, courthouses, airport hangars, or street improvements.
- Community support services, such as childcare centers, community centers, fairgrounds, or transitional housing.
- Public safety facilities and equipment, such as fire departments, police stations, prisons, police vehicles, fire trucks, public works vehicles, or equipment.
- Educational services, such as museums, libraries, or private schools.
- Utility services, such as telemedicine or distance learning equipment.
- Local food systems such as community gardens, food pantries, community kitchens, food banks, food hubs, or greenhouses.

**Federally qualified health centers (FQHC or health centers):** Under section 1905(l)(2)(B) of the Social Security Act (42 USC 1396[d]), an FQHC means an entity that

- (i) is receiving a grant under section 330 of the PHSA, or
- (ii) (I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 330 of the PHSA;
- (iii) based on the recommendation of the Health Resources and Services Administration (HRSA) within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant, including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity, or
- (iv) was treated by the Secretary, for purposes of part B of subchapter XVIII of this chapter, as a comprehensive Federally funded health center as of January 1, 1990; and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) [25 USC 450(f) et seq.] or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act [25 USC 1651 et seq.] for the provision of primary health services. In applying clause (ii), the Secretary may waive any requirement referred

to in such clause for up to 2 years for good cause shown.

FQHCs include all organizations receiving grants under section 330 of the PHSA. Health centers qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits, including the following:

- An annual federal operating grant from HRSA.
- Malpractice protection under the Federal Tort Claims Act.
- Access to discounted pharmaceuticals for patients through the 340B Drug Pricing Program.
- HRSA loan guarantee (when appropriated funds are available).

Health centers must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

Certain tribal organizations and health center look-alikes (see definition below) also may receive special Medicare and Medicaid reimbursement.

**Federal Tort Claims Act:** The Federally Supported Health Centers Assistance Act of 1992 and 1995 (FSHCA Act) granted medical malpractice liability protection through the Federal Tort Claims Act to HRSA-supported health centers. Under section 224 of the PHSA, as amended by the FSHCA Act of 1992 and 1995, employees of eligible health centers may be deemed to be federal employees qualified for protection under the FTCA. As employees of eligible health centers, they are considered federal employees and are immune from lawsuits, with the federal government acting as their primary insurer.

**Health center look-alikes:** A look-alike is an organization that meets all of the eligibility requirements of an organization that receives a PHSA section 330 grant, but does not receive grant funding. A look-alike receives many of the same benefits as FQHCs, including the following:

- Cost-based reimbursement for services provided under Medicare.
- Reimbursement under the Prospective Payment System or other state-approved alternative payment

methodology for services provided under Medicaid.

- Eligibility to purchase prescription and non-prescription medications for outpatients at reduced cost through the 340B Drug Pricing Program.
- Automatic designation as a Health Professional Shortage Area (HPSA). The HPSA designation provides eligibility to apply to receive National Health Service Corps personnel and eligibility to be a site where a J-1 Visa physician can serve.

**Health centers:** Under section 330(a), of the PHSA, codified at 42 USC 254(b), a health center is “an entity that serves a population in a medically underserved area, or a special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing by providing either directly through the staff and supporting resources of the center or through contracts or cooperative agreements required primary health services (as defined in section 330(b) (1)) and, as may be appropriate for particular centers, additional health services (as defined in section 330(b) (2)) necessary for the adequate support of the primary health services ...; for all residents of the area serviced by the center.”

Health centers provide high-quality preventive and primary health care to patients regardless of their ability to pay. Approximately one in 15 people in the United States relies on a HRSA-funded health center for medical care. Over 1,300 health centers operate 9,000 service delivery sites in every U.S. state; Washington, D.C.; Puerto Rico; the Virgin Islands; and the Pacific Basin. Combined, these centers care for nearly 23 million patients. For millions of Americans, including some of the most vulnerable individuals and families, health centers are the essential medical home where they find services that promote health, diagnose and treat disease and disability, and help them cope with environmental challenges that put them at risk.

Since 2010, health centers have become even more important to the nation’s health care system. As the centers have increased and expanded, the number of patients served has increased and the centers have added new full-time staff nationwide. For more information, visit the Health Resources and Services

Administration Health Center Program website.

**Health Resources and Services Administration (HRSA):** HRSA, an agency of the U.S. Department of Health and Human Services, is the primary federal agency for improving access to health care by strengthening the health care workforce, building healthy communities, and achieving health equity. HRSA’s programs provide health care to people who are geographically isolated or economically or medically vulnerable.

**Low-Income Housing Tax Credit (LIHTC) Program:** The LIHTC Program is the federal government’s primary program for encouraging the investment of private equity in the development of affordable rental housing for low-income households. Since its creation in 1986, the LIHTC Program has helped to finance more than 2.4 million affordable rental-housing units for low-income households. For more information, see the OCC’s *Community Developments Insights* issue on LIHTCs.

**Medically underserved areas or populations:** These are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty, or a large elderly population. Also called health professional shortage areas, these areas are designated because they have shortages of primary medical care, dental care, or mental health providers and may be geographic areas (a county or service area), populations (e.g., low income or Medicaid eligible) or facilities (e.g., FQHCs or state or federal prisons).

**New Markets Tax Credit (NMTC) Program:** The NMTC Program was designed to increase the flow of capital to businesses and low-income communities by providing a modest tax incentive to private investors. Over the last 15 years, the NMTC has proven to be an effective, targeted, and cost-efficient financing tool valued by businesses, communities, and investors across the country. For more information, see the New Markets Tax Credit Coalition’s fact sheet on the coalition’s website.

**Pay-for-performance and patient outcomes:** “Pay-for-performance” is an umbrella term for initiatives aimed at improving the quality, efficiency, and overall

value of health care. These arrangements provide financial incentives to hospitals, physicians, and other health care providers to carry out such improvements and achieve optimal outcomes for patients. In the traditional “fee for service” model, doctors are paid a set amount regardless of patient outcomes. Pay-for-performance has become popular among policymakers and private and public payers, including Medicare and Medicaid. There has been expansion in the use of pay-for-performance approaches, in Medicare in particular, and experimentation to identify designs and programs that are most effective. HealthAffairs.org provides more information on the topic.

**Preventive care:** The term preventive care is applied to health care and includes check-ups, patient counseling, and screenings to prevent illness, disease, and other health-related problems. Preventive health care services under the ACA are listed on the HHS Health Care website.

**Primary Care Associations (PCA):** PCAs are state or regional nonprofit organizations that provide training and technical assistance to safety-net providers. PCAs can help health centers and look-alikes plan for growth in their state and develop strategies to recruit and retain health center staff.

**Primary health care services:** Primary health care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis, and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, or day care). Primary care is also the level of a health services system that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions, and coordinates or integrates care, regardless of where the care is delivered and who provides it. Primary care is the means by which the two main goals of a health services system, optimization and equity of health status, are approached. Health centers deliver primary health care to patients, regardless of their ability to pay. The nation’s most vulnerable populations,

e.g., people who are homeless, farmworkers, or residents of public housing, rely on the Health Center Program, funded by the Bureau of Primary Health Care administered by HRSA, for care. Health centers champion preventive care and advance the medical/health home model of coordinated, comprehensive, and patient-centered care, coordinating a wide range of medical, dental, behavioral, and social services. Recent financial expansions of the Health Center Program are helping health center grantees serve more patients, stimulate new jobs, and meet the significant increase in demand for primary health care services among uninsured and underserved people.

**Prospective payment systems (PPS):** A PPS is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services). The Centers for Medicare and Medicaid Services uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice services, hospital outpatient facilities, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities.

**Qualified low-income community investment (QLICI):** A QLICI is an investment (such as a loan or equity investment) made by a community development entity in a qualified active low-income community business under the NMTC Program.

**Social determinants of health:** The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.

## Health Center Resource List

**A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment**, Executive Summary, Bipartisan Policy Center, April 2013.

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

**Community Development's Role in Disease Prevention**, S. Leonard Syme, PhD, Professor Emeritus, Epidemiology and Community, University of California, Berkeley; Federal Reserve Bank of San Francisco, March 10, 2014.

**Community Health Center Perspectives: Identifying the Risks of Health Center Lending: A Guide for Lenders**, Capital Link, October 2014.

**Community Health Centers at a Glance**, National Association of Community Health Centers, Inc., Fact Sheet #0313, March 2013.

**Community Health Centers in an Era of Health Reform: An Overview and Key Challenges to Health Center Growth**, Executive Summary, Kaiser Commission on Medicaid and the Uninsured, the Henry J. Kaiser Family Foundation, March 2013.

**Connecting Housing and Health Care Through Community Development**, Kevin Boes, Local Initiatives Support Corporation, **Community Investments**, spring 2013, volume 25, number 1.

"Federally Qualified Health Centers," Chapter 6 of the **Report to the Congress: Medicare and the Health Care Delivery System**, June 2011.

**Financial and Operational Ratios and Trends of Community Health Centers, 2008–2011**, Capital

Link and Community Health Center Capital Fund, Federal Reserve Bank of San Francisco, Community Development Investment Center, March 2014.

Financing Community Health Centers Resource Bank: **Training Curriculum, Financing Community Health Centers Resource Bank**, CDFI Fund, U.S. Department of the Treasury.

**Health Center Program Terms and Definitions**, Health Resources and Services Administration.

National Association of Community Health Centers Inc., **"America's Health Centers,"** Fact Sheet #0813, August 2013.

**Collaboration to Build Healthier Communities, A Report for the Robert Wood Johnson Foundation, Commission to Build a Healthier America**, June 19, 2013, publisher: Wilder Research/Federal Reserve Bank of Minneapolis, Mattessich, P.W., and Rausch, E.J.

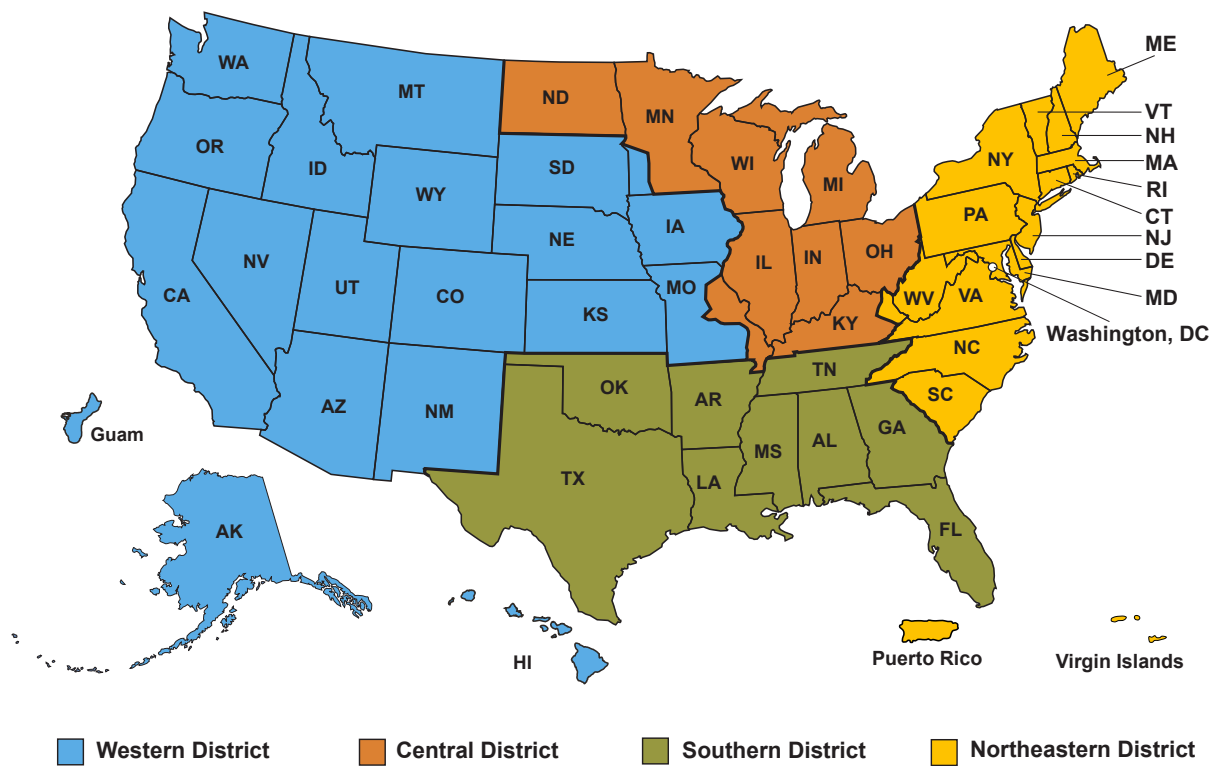
**The Converging Visions of Public Health and Community Development**, Conference Summary, Susan Longworth, ProfitWise News and Views, December 2013.

**The Impact of the Affordable Care Act on New Jobs**, J. Spetz, B. K. Frogner, L. Lucia, and K. Jacobs, Big Ideas for Job Creation, a Project of the Institute for Research on Labor and Employment at the University of California, Berkeley, 2014.

**The Impacts of Affordable Housing on Health: A Research Summary**, Nabihah Maqbool, Janet Viverios, and Mindy Ault, Center For Housing Policy, Insights From Housing Policy Research, April 2015.



**C**ommunity Affairs supports the OCC's mission to ensure a vibrant banking system by helping national banks and federal savings associations to be leaders in providing safe and sound community development financing and making financial services accessible to underserved communities and consumers, while treating their customers fairly.



E-mail and telephone information for the OCC's District Community Affairs Officers is available at [www.occ.gov/cacontacts](http://www.occ.gov/cacontacts).

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