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The Capital Investment Needs of Critical Access Hospitals (CAHs): Results of the 2007 National CAH Survey

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Introduction

Our nation's rural hospitals are aging, with many over fifty years old and in need of immediate renovation or replacement. For some, a significant portion of capital need involves the correction of building and life safety codes. Small rural hospitals typically face significant challenges to keep pace with depreciation, changing technology and patient needs, and the requirements of emerging performance and patient safety initiatives. While these needs are not unique to rural hospitals, access to capital by small rural hospitals has been uneven.

Lenders of capital have typically considered small rural hospitals to be high-risk borrowers due to their historic losses, recruitment issues, and their need to keep pace with underfunded liabilities (e.g., depreciation, pension plans and malpractice insurance). As a result, lenders tend to hold small rural facilities to higher investment standards than their financial performance might otherwise suggest.

Strengthening the economic viability of CAHs to maintain access to quality healthcare services for rural areas is a major goal of the Medicare Rural Hospital Flexibility Program. However, while reduction in bed size is a core strategy for enhancing performance efficiencies in CAHs, their smaller size magnifies any credit deficiencies and otherwise limits the kind of financial flexibility that lenders seek to allay risk.

Approach

This policy brief describes the findings of a national telephone survey of CAHs to determine the nature of their capital needs and experiences in accessing capital to meet those needs. The survey was conducted from January to May of 2007. A total of 381 administrators responded to the survey (85% response rate). Participating hospitals had at least one full year of operation as a CAH. All 45 Flex Program states are represented.

Key Findings

- The surveyed CAHs reported a total capital need of $2 billion. Of this total, $1.2 billion was for itemized needs related to operational effectiveness, new hospital construction, and fire and life safety compliance.
- CAHs' reported capital needs for investment in health information technology have doubled since 2004.
- 83% of the surveyed CAHs that pursued a capital loan during the two years preceding the survey were successful.
- Over half of all surveyed CAHs that sought funding to replace their physical plant were successful.
- Approximately 10% of all CAHs that could not pursue a capital loan because of their debt burden or inability to meet other investment criteria also reported a need to improve or expand their fire suppression systems.
- The total estimated unmet capital need for the 1,267 CAHs in operation as of December 2005 is $4.5 billion.

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Results

Total capital need for all surveyed CAHs is $2 billion. Of this total, $1.2 billion involved improving operational efficiencies ($650 million), facility replacement ($469 million), and compliance to fire and life safety (F&LS) codes ($80 million).

For the most part, operational performance projects and costs were similar to those reported in the 2004 national survey of CAHs.[1] However, while the average cost for hospital renovation increased between 2004 and 2007, fewer projects were identified in 2007 (24% versus 35%). The most notable difference between the two surveys was a doubling of reported capital need for HIT ($46 million) and a tripling of HIT projects.

Although fire and life safety project needs represent the smallest portion of total need, they are among the most critical. Just over one-half of all F&LS projects (52%) involve installing, updating, or replacing fire suppression systems. Fire and smoke barriers account for an additional 27 percent of F&LS projects.

Of CAHs that sought a capital loan during the past two years, 83% were successful, including half of those seeking funds to replace their total physical plant. In our 2004 report, no CAHs reported receiving a loan for applications for facility replacement.

Over one-half of the CAHs that did not seek a loan reported either having no need (17%) or having alternative sources of funding available (39%). The proportion of CAHs that did not seek a loan because of poor financial performance or history fell by one half compared to those in 2004.

Policy Implications

Survey findings suggest that access to capital has improved since 2004. Although the increase in successful loans for facility replacement may reflect the larger trend occurring in the hospital sector, CAH replacements are occurring for hospitals that previously could not meet investment-grade benchmarks.

Some CAHs did not attempt to obtain a capital loan because of a high level of debt or their realization that they could not meet the investment criteria of lenders. Approximately 10% of these hospitals reported a need to improve or expand their fire suppression systems. The ability of CAHs to meet these and other important infrastructure needs today has been further complicated by the collapse of the subprime bond market, the subsequent tightening of credit availability, and losses in investment income.

Based on our survey results, we estimate that the total unmet capital need for CAHs certified as of December 2005 is $4.5 billion. Until bond markets rebound and credit availability improves, many CAHs will face significant hurdles just to keep pace with depreciation and some may face choices that are even more difficult.

Endnotes

[1] *Gregg, W. The availability and use of capital by Critical Access Hospitals. (Briefing Paper No. 4). Minneapolis, MN: Flex Monitoring Team; March 2005.*

Additional Information

This policy brief is based on Flex Monitoring Team Briefing Paper No.21 available at http://www.flexmonitoring.org/documents/BriefingPaper21_CAHAccessToCapital.pdf

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