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Navigating a Rapidly Changing, Rising Rate Environment

The Hill-Burton program which operated from 1946 to 1975 supported the development of 6,800 healthcare facilities across the United States with a particular emphasis on rural areas to address healthcare access.

Now nearly 50 years later many of these facilities are well beyond their useful lives and require significant reinvestment of resources to modernize and update the healthcare infrastructure to address today's challenges and needs. Research on Critical Access Hospitals (CAH) shows billions of dollars of need to address deficiencies, and successfully meeting these needs represents a significant challenge given the high cost of healthcare facility construction and an operating environment of limited financial resources.

The USDA's Community Facilities program has a mission to help ensure that people living in rural places enjoy "the same basic quality of life and services enjoyed by those in urban areas," and under this program, they offer grants and loan programs with below market rates. Because health care is one of the most essential and foundational services to support local rural economic development, the community facilities program regularly makes loans to assist CAHs in upgrading their facilities to meet community needs. The primary factors associated with being able to access these resources for a CAH are:

1. **Interest rates and terms**
2. **Total project costs**
3. **Cash flow and resources available for debt payments**
4. **The overall mix of cost-based payments to offset increased capital costs**

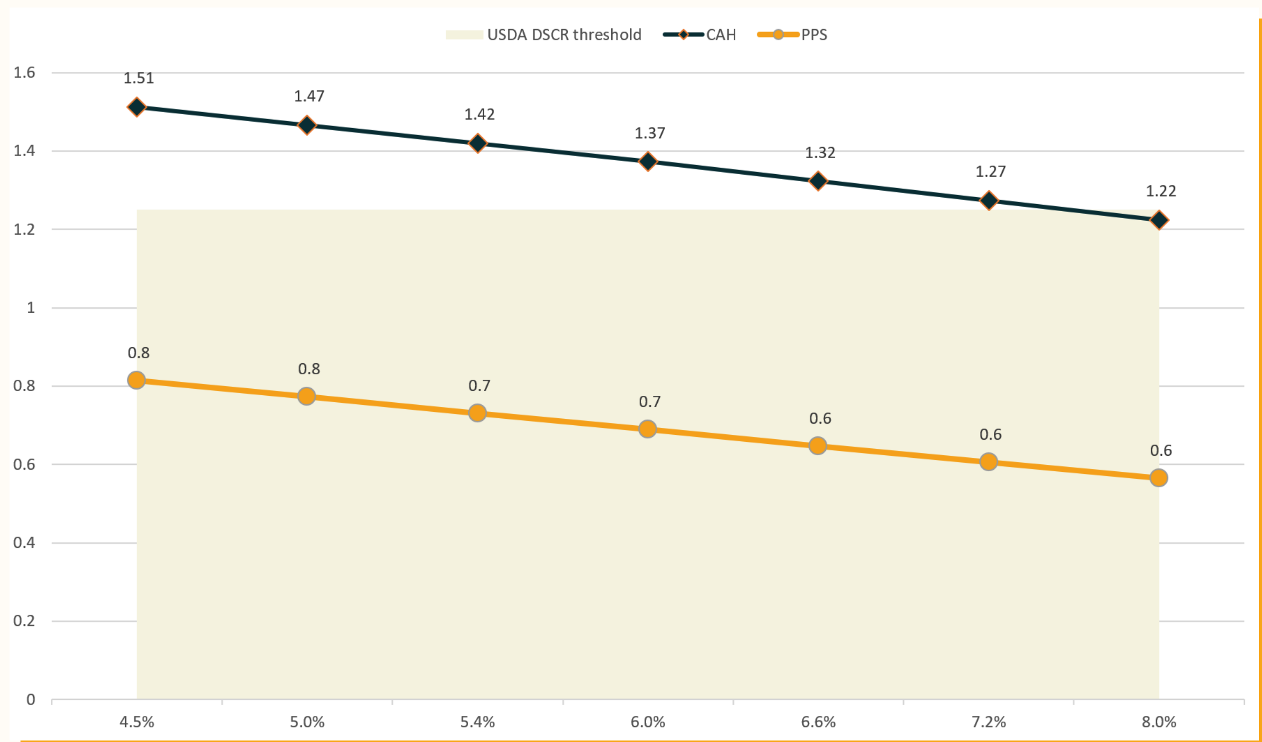
Over the past 12 months, both construction costs and interest rates have risen dramatically.

The challenge for CAH executives, board members, and key stakeholders is that despite these trends, the internal needs for capital are only becoming more urgent and acute. Therefore, the question of whether or not planning a capital investment to meet the community's needs in an environment where interest rates are higher than recent past is now paramount to planning success. To examine this question, we looked at the impact of healthcare cost inflation and rising interest rates on the ability to qualify for loan funds and demonstrate a sustainable plan for loan repayment.

The metric we examined across different financing scenarios for a typical CAH is the debt service coverage ratio (DSCR) which represents the relationship of the cash flow available for paying long-term debt to the annual principal and interest payments. The USDA program typically requires between a 1.1 and 1.25 coverage ratio indicating that for each dollar of debt payments, the organization is generating an extra $0.10-$0.25 of excess cash flow ("coverage") for operations and other routine capital needs.

Below is the impact of rising interest rates on the affordability of a hypothetical CAH project that totals $20 million with $1 million of cash flow annually and a 45% overall cost-based payer mix. The baseline starting point assumes a 4.5% interest rate financed over 30 years.

Impact of interest rate on debt service coverage ratio (DSCR) $20M loan, 4.5-8% interest rate, 30 years, $1M EBITDA, 45% cost-based



The chart above indicates the debt service coverage ratio (DSCR) for each scenario of a 10% increase in interest rates. For example, if the project were funded at a 4.5% rate in the baseline scenario on the far left, then the CAH DSCR would be 1.51 (as indicated on the dark blue line with diamond markers). If that rate increased to 5.0% in the next scenario to the right, then the debt service coverage would decrease to 1.47. The analysis further shows that an even more substantial increase in the interest rate to 8% reduces the debt service coverage ratio to 1.22 which remains within the required USDA threshold of 1.1-1.25.

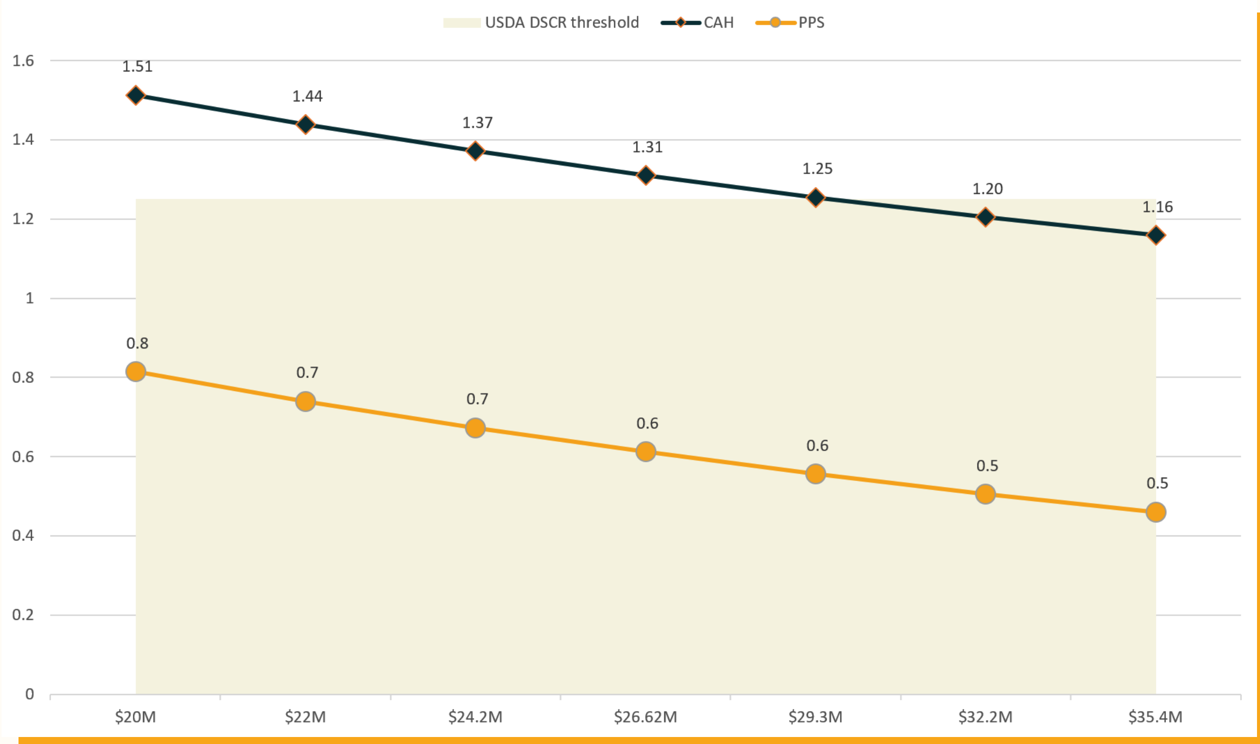
For comparative purposes and to illustrate how cost-based payments offset interest rate risk for CAHs, the chart also shows the debt service coverage ratio for a hospital that does not receive cost-based payments and is instead paid according to the Medicare fee schedule (the "Prospective Payment System" [PPS]) which fall below the required USDA threshold of a 1.25 DSCR in all scenarios. This demonstrates the significant benefit of cost-based payments for capital investments based on the increased depreciation and interest from the project.

This analysis reflects that interest rates paid by CAHs are not a highly sensitive variable (i.e., changes in interest rates do not create a big difference in the DSCR) because some of the increased costs are being offset through the additional reimbursement on the cost report. Based on this analysis the current rising interest rate environment should not be a deterrent to CAHs planning for long-term capital investments.

Another factor to consider is the overall project cost and therefore the amount of resource that needs to be borrowed. Here, the healthcare market has seen more than a typical decade's worth of cost inflation compressed into the last couple of years. Construction cost escalation has reportedly slowed from its high of a 1% increase per month to a projected 4 to 5% for the next year, and yet despite the slowing of growth, project costs will continue to rise steadily. Assuming that the underlying facility needs are not going away, this compels consideration for making an investment before costs escalate further and potentially result in unaffordable projects and leaves the community needs unmet.

Like the analysis on interest rates, below is the impact on the debt service coverage ratio for a project that ranges from $20 million to $35.4 million.

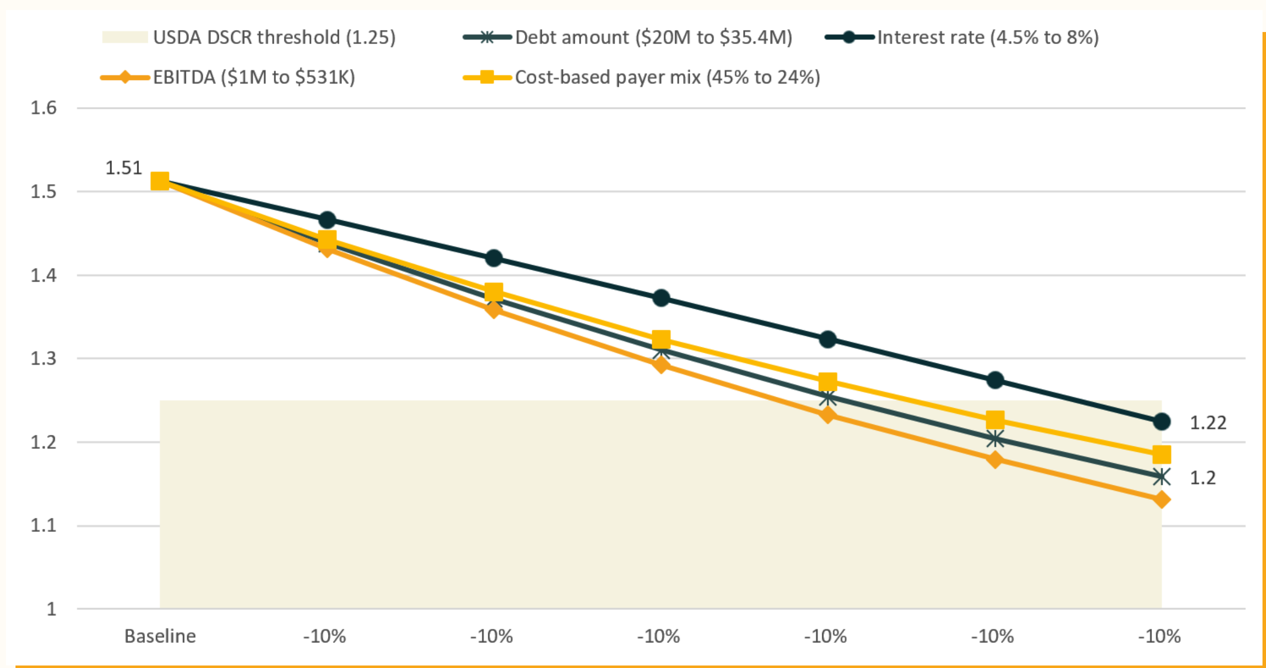
Impact of loan amount on debt service coverage ratio (DSCR) $20M-$35.4M, 4.5% interest rate, 30 years, $1M EBITDA, 45% cost-based



In line with the analysis on the impact of interest rates presented above, the impact of increased costs is moderated for CAHs based on the cost-based reimbursement system. This helps moderate the impact of project cost inflation. The benefit of the cost-based payments overall are reflected in the gap that between the CAH and PPS lines shown above with the CAH line being better (higher) than PPS results in all scenarios.

The chart below compares all the additional factors for consideration in planning a capital investment and shows that the change in cash flow available for debt repayment is the most important factor (i.e., changes lead to the biggest impact in the project's feasibility), followed by the project size (i.e., debt amount) and the cost-based payer mix. Of all the factors impacting the feasibility of the project, interest rates are the least important.

Factors Impacting Debt Service Coverage Ratio (DSCR) Comparison of the impact from a 10% change per factor Baseline = $20M loan, 4.5% rate, $1M EBITDA, 45% cost-based

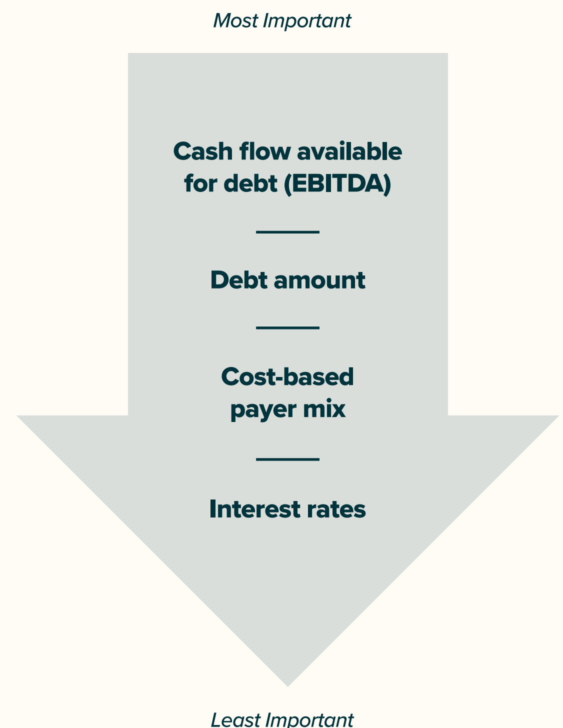


Both the health care and the financial markets are changing regularly.

This analysis demonstrates that for Critical Access Hospitals the impact of these key market changes are mitigated through the reimbursement system. This leads to the following takeaways:

1. **Sizing the project to meet the community needs and the resources available is the critical first step in developing a baseline strategy that accommodates potential market changes during the planning and financing process while maintaining the project's feasibility.**
2. **Healthcare construction inflation, while moderating, is projected to continue to increase annually making needed investments more and more costly the longer an organization delays addressing the need.**
3. **The period of increased interest rates in the current market is not a deterrent to planning a successful facility investment for Critical Access Hospitals—in fact because interest rates are cyclical, it provides an opportunity to allow for interest rates to come back down by planning early, or refinancing the debt in the future when rates fall.**

Most Important



Least Important

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