

February 2006

HOSPITAL
MORTGAGE
INSURANCE
PROGRAM

Program and Risk
Management Could Be
Enhanced



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Highlights

Highlights of [GAO-06-316](#), a report to congressional committees

Why GAO Did This Study

Under its Hospital Mortgage Insurance Program, the Department of Housing and Urban Development's (HUD) Federal Housing Administration (FHA) insures nearly \$5 billion in mortgage loans for the renovation or construction of hospitals that would otherwise have difficulty accessing capital. In response to a requirement in the 2005 Consolidated Appropriations Conference Report, GAO examined (1) the design and management of the program, as compared with private insurance, (2) the nature and management of the relationship between HUD and the Department of Health and Human Services (HHS) in implementing the program, (3) the financial implications of the program to the General Insurance/Special Risk Insurance (GI/SRI) fund, including risk posed by program and market trends, and (4) how HUD estimates the annual credit subsidy for the program, including the factors and assumptions used.

What GAO Recommends

GAO recommends that the HUD Secretary ensure that program performance measures are useful, update the program handbook, develop a formal geographic diversification strategy, and explore adding factors to HUD's credit subsidy model. HUD agreed with GAO's recommendations but said that the report did not adequately emphasize the program's accomplishments.

www.gao.gov/cgi-bin/getrpt?GAO-06-316.

To view the full product, including the scope and methodology, click on the link above. For more information, contact David G. Wood at (202) 512-6878 or WoodD@gao.gov.

HOSPITAL MORTGAGE INSURANCE PROGRAM

Program and Risk Management Could Be Enhanced

What GAO Found

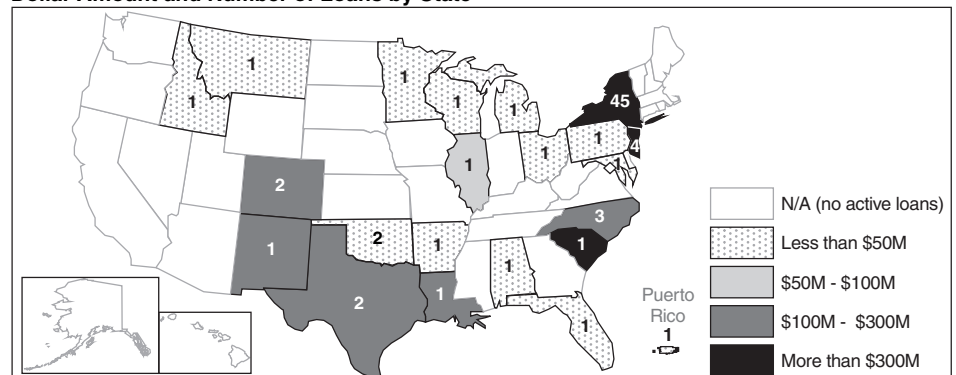
The Hospital Mortgage Insurance Program insures the mortgages of hospitals that are generally riskier than those that can obtain private bond insurance. While FHA's process for reviewing mortgage insurance applications includes more steps and generally takes longer, the agency monitors active loans with many of the same techniques that private bond insurers use.

Under a Memorandum of Agreement, FHA and HHS work together in a variety of ways to review mortgage insurance applications and monitor active loans. However, FHA does not collect data to assess program performance against most performance measures specified in the memorandum, some of which are not objective. Further, FHA has not kept its program handbook of policies and procedures for applicants, lenders, and others up-to-date.

The hospital program is small compared with other programs in the GI/SRI fund, and the losses from claims have been relatively low. Despite the program's relatively small size, some program and market trends may pose risks. For example, 61 percent of the program's total insured, outstanding loan amount is concentrated in New York, which makes the program vulnerable to state policies and regional economic conditions. While FHA has goals to diversify the hospital insurance portfolio and has made efforts to do so, it does not have a formal strategy to achieve these goals.

To estimate the credit subsidy cost, or program costs, over the life of the outstanding loans insured, HUD uses a model that incorporates factors and assumptions about how loans will perform, including estimated claim and recovery rates, which are consistent with federal guidance. However, HUD's model does not explicitly consider some factors, such as the potential impacts of prepayment penalties or restrictions, which according to some economic studies, are important in modeling default risk.

FHA Hospitals Remain Concentrated in the Northeast as of December 2005: Active Loan Dollar Amount and Number of Loans by State



Sources: GAO analysis of HUD's F47 database, a multifamily database (data); Art Explosion (map).

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Abbreviations

AE	Account Executive
CAH	Critical Access Hospitals
CMS	Centers for Medicare & Medicaid Services
FHA	Federal Housing Administration
GI/SRI	General Insurance/Special Risk Insurance
HHS	Department of Health and Human Services
HMIMIS	Hospital Mortgage Insurance Management Information System
HUD	Department of Housing and Urban Development
MOA	Memorandum of Agreement
OMB	Office of Management and Budget
PART	Program Assessment Rating Tool
PMG	Program Management Group
PWL	Priority Watch List

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United States Government Accountability Office
Washington, D.C. 20548

February 28, 2006

The Honorable Christopher Bond
Chairman
The Honorable Patty Murray
Ranking Member
Subcommittee on Transportation,
Treasury, the Judiciary, Housing and Urban
Development, and Related Agencies
Committee on Appropriations
United States Senate

The Honorable Joe Knollenberg
Chairman
The Honorable John W. Olver
Ranking Member
Subcommittee on Transportation, Treasury, and
Housing and Urban Development, The Judiciary,
District of Columbia, and Independent Agencies
Committee on Appropriations
House of Representatives

The Department of Housing and Urban Development (HUD), through the Federal Housing Administration's (FHA) Hospital Mortgage Insurance Program, insures loans to finance the renovation or construction of hospitals. Through an interagency agreement, the Department of Health and Human Services (HHS) administers certain aspects of this program based upon its health care and hospital expertise. The program is intended to protect lenders against losses they might incur if hospitals fail to make their mortgage payments. As of December 31, 2005, FHA reported that it insured nearly \$5 billion in outstanding mortgages under the program.

The Hospital Mortgage Insurance Program is one of several programs included in FHA's General Insurance/Special Risk Insurance (GI/SRI) fund; other programs in the GI/SRI fund are much larger and include mortgage insurance for various types of multifamily housing projects and for nursing homes. Pursuant to the Federal Credit Reform Act of 1990, for budget purposes HUD must annually estimate the credit subsidy for the program.¹

¹2 U.S.C. secs. 661-661f. In this report, we refer to the requirement of the act as "credit reform."

The credit subsidy cost for loan guarantees is the present value of cash flows over the life of the loan from estimated payments by the government (for defaults, delinquencies, and other payments) minus estimated payments to the government (for loan origination and other fees, penalties, and recoveries); it excludes administrative costs. Such estimates are important indicators of the full cost of programs to the government.

The 2005 Consolidated Appropriations Conference Report mandated that we review two FHA insurance programs—those for hospitals and nursing homes. This report provides the results of our evaluation of the Hospital Mortgage Insurance Program.² For this report, we reviewed (1) the design and management of the program, as compared with private insurance; (2) the nature and management of the relationship between HUD and HHS in implementing the program; (3) the financial implications of the program to the GI/SRI fund, including risk posed by program and market trends; and (4) how HUD estimates the annual credit subsidy for the program, including the factors and assumptions used.

To address these objectives, we reviewed program manuals and documentation of loan processing procedures and analyzed program financial data, which we determined to be reliable for the purposes of our review. We also reviewed documentation of HUD's credit subsidy model and applicable program laws, regulations, and policy statements. We interviewed officials from FHA's Office of Insured Health Care Facilities and the Division of Facilities and Loans within HHS' Health Resources and Services Administration. We also interviewed health care and hospital associations, mortgage and investment banking firms, rating agencies, and private bond insurers. Our review of the hospital program did not include an evaluation of underwriting criteria, construction monitoring, or the need for the program. See appendix I for more detailed information on our objectives, scope, and methodology.

We conducted our work in New York, New York; Chicago, Illinois; Paterson, New Jersey; Rockville, Maryland; and Washington, D.C., between February 2005 and January 2006 in accordance with generally accepted government auditing standards.

²The results of our study on the nursing home insurance program will be provided in a separate report.

Results in Brief

The Hospital Mortgage Insurance Program insures the mortgages of hospitals that are financially riskier than those that can obtain private insurance, but it shares some management techniques with private insurers. While FHA's process for reviewing mortgage insurance applications includes more steps, such as a preapplication meeting and review by an independent consultant, and generally takes longer, FHA officials believe these extra steps are justified given the generally riskier nature of the hospitals applying. Once it insures a hospital mortgage, FHA monitors the loan using many of the same techniques that private insurers use. For example, both FHA and private insurers identify the riskiest loans in their portfolios for closer monitoring. They also periodically review hospital financial statements and management activities and can require hospitals experiencing financial difficulties to use consultants for needed expertise.

FHA and HHS work together throughout the process of reviewing mortgage insurance applications and monitoring active loans, guided by a multiyear Memorandum of Agreement between the two agencies. However, FHA has not used the agreement's performance measures to manage the program, and its program guidance is not up to date. FHA and HHS use joint working groups to carry out certain activities. For example, client service teams, which can be composed of HHS staff, FHA staff, or both, review application materials. Also, senior FHA and HHS officials meet weekly to discuss insurance applications, as well as insured hospitals that are experiencing difficulties. While the agencies coordinate in program implementation, FHA does not collect data to track most of the performance measures, including those for coordinated or HHS-delegated tasks. For example, one performance measure is designed to capture the soundness of the analysis of a hospital's application, but FHA does not collect data to assess this performance measure. Other performance measures are not measurable or objective. According to FHA, the measures are intended to communicate expectations, and it has not tracked most performance measures because there have not been enough problems to warrant a tracking system. Finally, FHA has not updated the program handbook, which contains program eligibility requirements, policies, and procedures, since 1984.

The Hospital Mortgage Insurance Program is small compared with other programs in the GI/SRI fund—accounting for about 7 percent of the amount of all active loans insured by the fund—and the losses from claims have been relatively low. The program has not experienced a claim since

1999. Despite the program's relatively small size, some program and market trends may pose risks. For example, the geographic concentration of insured hospitals located in the state of New York, while decreasing, makes the program vulnerable to state policies and regional economic conditions. In addition, literature on hospital industry market trends generally predicts reductions in hospital revenues along with increasing capital needs—conditions that could increase the risk of FHA insured loans going to claim. FHA has established mitigation strategies to address some potential risks. For example, FHA requires hospitals to establish cash reserve funds equal to 2 years worth of mortgage payments. These funds may be used to help hospitals through temporary financial crises and prevent their lenders from filing an insurance claim. Also, FHA's identification of its riskiest hospitals enables the agency to prioritize those hospitals that need additional monitoring and assistance. In addition, since 1999, FHA has had goals for geographically diversifying the hospital mortgage insurance portfolio. Though it has made efforts to diversify the portfolio, FHA does not have a formal strategy for reaching its diversification goals.

HUD uses a model for estimating annual credit subsidies, or program costs over the life of the outstanding loans insured, that does not explicitly consider the impacts of some potentially important factors. HUD's model—an important tool for estimating the cost of the hospital program to the government—incorporates factors and assumptions about how the loans will perform, including estimated claim and recovery rates, which are consistent with guidance issued by the Office of Management and Budget (OMB). Although the number of claims paid since the program's inception is small, HUD assumes that the lenders for some active hospitals will file claims for insurance and, therefore, increases its estimated claim rate. In 10 of the 14 years that HUD has been estimating the cost of the hospital program under credit reform, HUD has calculated a negative subsidy rate, meaning that estimated cash inflows (including fees, premiums, and recoveries on defaulted loans) have been greater than estimated cash outflows (including claims and certain program expenses). HUD's model does not explicitly consider the potential impacts of prepayment penalties or restrictions, which can influence cash flows through the timing of prepayments, collection of premiums, and claims. HUD's model also does not consider the initial debt-service coverage ratios of hospitals (an indicator of a borrower's ability to make regular mortgage payments) at the point of loan origination when estimating future claims, although, according to some economic studies, this ratio is an important factor in modeling default risk. HUD does not include these factors in its model because, according to HUD, it does not collect data on prepayment

restrictions and because debt-service coverage ratios, among other things, do not vary. We found that data on prepayment restrictions are readily available to FHA. Further, our analysis of projected debt-service coverage ratios for hospitals that applied for mortgage insurance between 2002 and 2005 found that these ratios varied (with the highest being over twice that of the lowest) and thus can be useful in assessing relative risk.

This report contains recommendations designed to improve FHA's management of the Hospital Mortgage Insurance Program and reduce risks associated with the geographic concentration of the portfolio. We provided draft copies of this report to HUD and HHS. In its response, HUD's Assistant Secretary for Housing concurred with our recommendations and noted actions that it plans to take. HUD also stated that the report did not adequately emphasize the program's accomplishments. HHS concurred with HUD's observations.

Background

In 1968, the Congress added Section 242 to the National Housing Act establishing the Hospital Mortgage Insurance Program to address a serious shortage of hospitals and the need for existing hospitals to expand and renovate. Through this program, FHA insures the loans lenders make for the construction and renovation of hospitals.³ Since the inception of the program, FHA has insured 341 hospital mortgages for \$11.9 billion in 42 states and Puerto Rico. As of the end of calendar year 2005, FHA was insuring 74 hospital mortgages totaling nearly \$5 billion.⁴ The number of loans insured annually has increased in recent years, from 2 in fiscal year 2001 to 11 in fiscal year 2005 (see table 1). According to the House report accompanying the Hospital Mortgage Insurance Act of 2003, which revised the standards for determining the need and feasibility for hospitals, as well as eligibility requirements for small, rural hospitals, hospitals face significant financial challenges when providing care to patients who are covered by Medicare and Medicaid, as well as those that are uninsured. At the same time, improvements in technology and health care knowledge necessitate capital improvements such as additions and renovations to existing buildings.

³The Hospital Mortgage Insurance Program supplemented the Hill-Burton Program. Under Hill-Burton, HHS, formerly the Department of Health, Education, and Welfare, made loan guarantees and direct loans to hospitals for construction and modernization projects.

⁴FHA was insuring 74 mortgages for 59 hospitals as of December 2005.

Table 1: Number of New Loans Insured through the Hospital Mortgage Insurance Program Since 2001

Fiscal year	Loans insured
2005	11
2004	6
2003	7
2002	1
2001	2

Source: FHA.

FHA's Office of Insured Health Care Facilities and HHS' Division of Facilities and Loans coordinate to implement the hospital program. HUD has statutory responsibility for the program based on the FHA's experience with promoting housing construction through housing mortgage insurance programs. As such, HUD is fully responsible for management of the program, including developing and proposing legislation, policy development, strategic planning, and approval of applications and loan documents. The House Committee on Banking and Currency, in recommending that HUD be given this responsibility, expected HUD to draw upon HHS's hospital expertise to devise standards for insuring hospitals' mortgages. Through an interagency agreement, HUD formally delegates authority to HHS to assist in the review of applications for mortgage insurance and the monitoring of insured loans. HHS is also given full responsibility for construction monitoring. See appendix II for additional information about FHA and HHS's loan processing responsibilities.

FHA's Hospital Mortgage Insurance Program generally serves the segment of the market consisting of hospitals that are too risky to obtain private bond insurance but are strong enough to pass FHA's underwriting tests. Mortgage insurance, like private bond insurance, guarantees that lenders will be paid if the hospital stops making payments on its loan. In addition, both mortgage insurance and private bond insurance are forms of credit enhancement and improve the credit rating of the underlying debt for the insured entity, resulting in a lower interest rate for the loan. Hospitals with FHA-insured mortgages automatically receive investment-grade ratings (AA or AAA) because the reliability of the cash flows from the mortgage note are rated on the insurer's, not the hospital's, ability to repay the debt. Both FHA and HHS officials and private insurers agree that FHA's Hospital Mortgage Insurance Program serves a different market than private

insurers. According to FHA and HHS officials, FHA insures loans that are too risky, too small, or too large for private insurers, or are located in a market not served by private insurers.

For the Hospital Mortgage Insurance Program, if a hospital fails to make any payment due under the mortgage, the mortgage is in default. If a default continues for 30 days, the lender is entitled to receive benefits from FHA. FHA may pay claims in either cash or debentures.⁵

Federal agencies that provide direct loans or loan guarantees are required by the Federal Credit Reform Act of 1990 to estimate the expected cost of programs by estimating or predicting their future performance and reporting the costs to the government in their annual budgets. Such estimates are important in that they more accurately measure the government's costs of federal loan programs and permit better cost comparisons among different programs. Under credit reform procedures, the cost of loan guarantees, such as mortgage insurance, is the net present value of all expected future cash flows, excluding administrative costs.⁶ For guarantees, cash inflows consist primarily of fees and premiums charged to insured borrowers and recoveries on assets, and cash outflows consist mostly of payments to lenders to cover the cost of claims. Agencies discount projected future cash flows to the year in which the guaranteed loan was disbursed. The discounted cash flows are the estimated budgetary cost or gain of the cohort of loans obligated in a given fiscal year.⁷ The net present value of each cohort's estimated cash flows is expressed as a percentage of the volume of guaranteed loans in the cohort—that is, a subsidy rate. Agency managers are responsible for accumulating relevant, sufficient, and reliable data on which to base their credit subsidy estimates.

⁵In a cash pay transaction, FHA will pay approximately 90 percent of the claim within a few days of when the mortgage is assigned to FHA. The remaining 10 percent is generally paid at a later date, after FHA has completed its due diligence in processing the claim and the title passes to FHA. Debentures are financial instruments with 20-year terms issued by FHA that pay interest semiannually. Interest on the debenture is used to pay principal and interest on the bonds.

⁶Present value is the worth of the future stream of cash inflows and outflows, as if they had occurred immediately. Calculating present value for credit reform requires the utilization of the interest rate on a marketable zero-coupon Treasury security with the same maturity from the date of disbursement as the cash flow provides the basis for converting future amounts into their "money now" equivalents. Net present value is the present value of estimated future cash inflows minus the present value of estimated future cash outflows.

⁷A cohort refers to all direct loans and loan guarantees obligated in a given fiscal year.

OMB has final responsibility for determining subsidy estimates, in consultation with agencies.

FHA's Selection Process Includes Additional Steps Compared with Private Insurers, but Monitoring Techniques Are Similar

FHA requires hospitals to take certain steps, both before they apply for mortgage insurance and as a part of the application process, that private insurers do not mandate. These additional steps are used because FHA insures mortgages that are generally riskier than those using private bond insurance. For example, before they apply for mortgage insurance, FHA advises hospitals to compare their financial status with the program's minimum requirements. If they meet these requirements, FHA requires hospitals to submit market and financial information so that FHA can make a preliminary assessment about the project and determine whether to conduct a preapplication meeting with the applicant to discuss the project. None of the private insurers that we met with have similar preapplication processes.

After these preapplication steps are met, FHA's application process includes additional steps compared with those of private bond insurers. FHA requires hospitals to submit a financial feasibility study containing historic and forecasted financial statements and ratios, a financing plan, and information about market demand, among other things. In addition, FHA hires consultants to evaluate the feasibility of each proposed project as an additional, independent check on the viability of the project. While the private bond insurers that we met with review the types of information included in feasibility studies, they do not require hospitals to submit such studies and do not hire consultants to assess the feasibility of proposed projects.

FHA's application process also includes a final level of review that is absent from private bond insurer processes. After an application for mortgage insurance has gone through underwriting and been reviewed by an independent consultant, it is considered by the program management group, a group of senior-level FHA and HHS staff. FHA also refers to this group as its "credit committee." Similarly, private bond insurers also consider applications within a credit committee structure. However, while private bond insurers make final insurance decisions through their credit committees, FHA has an additional layer of review. Based upon input from the program management group, the Director of FHA's Office of Insured Health Care Facilities makes a recommendation to the FHA Commissioner, who then makes the final decision.

It generally takes FHA longer to process applications than it takes private bond insurers. According to program data, it took FHA an average of 265 days to process the 11 applications for hospital mortgage insurance that it endorsed in fiscal year 2005.⁸ According to the FHA, processing times vary with the complexity of the project and may be affected by issues requiring a hospital to rethink or resubmit its application, including issues that are beyond HUD's control. In contrast, according to the private bond insurers and investment bankers that we interviewed, it generally takes private insurers up to 60 days to process an insurance application, sometimes less. While FHA's average processing time is higher than private bond insurers, it has decreased from an average of 399 days in fiscal year 1999. According to FHA, processing times have improved as a result of implementing the preliminary review process, which disqualifies hospitals that don't meet the program's minimum requirements.

FHA uses many of the same techniques that private insurers use to monitor insured hospitals. Both FHA and private bond insurers identify the riskiest hospitals in their portfolio for closer monitoring. Since November 1999, FHA has placed on a priority watch list hospitals it determines are at risk of having a claim filed within the next 12 months. FHA considers a hospital for inclusion on the priority watch list if certain financial criteria are not met. For example, if the ratio measuring a hospital's ability to pay its mortgage payments with cash generated from current operations (the debt service coverage ratio) falls below an acceptable level, the hospital may be placed on the watch list.⁹ A hospital can also be placed on the list if FHA becomes aware of other conditions at the hospital, such as management or personnel problems. As of December 2005, FHA data showed that 11 of the 59 insured hospitals are on this list, representing an unpaid (insured) principal balance of approximately \$762 million. Private insurers also assess the risk of the hospitals that they insure in order to identify those that should be monitored more closely. For example, one private bond insurer explained that they monitor compliance with loan agreements by reviewing financial statements, documentation of payer mix (i.e.,

⁸This figure is based on the number of days elapsed from the point that a complete application has been received to the point that HUD makes a decision to either commit to insuring the project, or rejects the application.

⁹While FHA requires applicants to provide data showing historical and projected debt-service coverage ratios, and monitors this ratio for insured hospitals, it does not explicitly factor the ratio into its forecast of loan performance when estimating credit subsidies. This issue is discussed in more detail later in this report in the section on FHA's credit subsidy model.

proportion of reimbursement from Medicare, Medicaid, private insurance, etc.), and notices of litigation, among other things.

As a part of their monitoring efforts, both FHA and private bond insurers monitor agreements that exist between themselves and the insured hospital.¹⁰ These agreements specify the requirements that the insured hospital must comply with in order to maintain the insurance. Agreements may cover issues such as the debt-service coverage ratio; liquidity, or the ability to convert assets to cash; and activities that a hospital cannot do without approval by the insurer. Both FHA and private insurers require hospitals to request waivers from agreement requirements if they are not going to meet them. FHA and private insurers monitor hospitals' compliance with these agreements through various means, such as by evaluating changes in indicators of financial performance, as reported in hospitals' financial statements. For example, one private bond insurer reported that it monitors hospitals' cash on hand, and FHA monitors hospitals' debt-service coverage ratios. FHA and private insurers monitor financial statements and other documentation quarterly and annually, respectively, and more frequently for hospitals that are experiencing financial difficulty. Both FHA and private insurers require hospitals that are not in compliance to correct violations within specific time frames.

¹⁰FHA's Regulatory Agreement contains covenants, or requirements that must be adhered to. In addition, FHA can require hospitals to adhere to supplemental covenants.

Both FHA and private insurers can require hospitals experiencing financial difficulties to hire consultants. In some cases, FHA will pay for consultants to identify and suggest solutions to hospitals' financial difficulties. According to FHA, since fiscal year 2000, it has paid \$1.3 million for consultant's studies of 27 hospitals.¹¹ However, FHA can also require hospitals to hire and pay for consulting services on their own. Similarly, private insurers can require hospitals to hire consultants to assist them with identifying and addressing problems. The requirement for a hospital to hire a consultant can be triggered if a hospital is not in compliance with its loan agreements, according to both FHA and private bond insurers.¹²

Agencies Coordinate Key Activities, but FHA Does Not Track Most Performance Measures

FHA and HHS coordinate key activities, including screening applicants, underwriting loans, and monitoring insured hospitals. While FHA has established performance measures for both coordinated tasks and tasks delegated to HHS through an interagency agreement, it does not collect data with which to assess most of these measures. FHA's primary guidance for the program has not been updated in over 20 years and, therefore, does not reflect key changes in eligibility criteria.

¹¹This figure does not include financial feasibility study reviews, which are done as a part of FHA's application review process.

¹²According to FHA, hospitals can also be required to hire consultants if they fail to meet certain minimum financial ratios, incur a significant adverse difference between budgeted and actual performance, or experience significant adverse changes in reimbursement rates.

FHA and HHS Coordinate Their Client Screening, Application Review, and Loan Monitoring Activities

FHA and HHS coordinate to implement the hospital program based upon FHA's experience with promoting housing construction through its housing mortgage insurance programs and HHS's hospital and health care expertise. As previously noted, FHA is responsible for management of the program and formally delegates certain responsibilities to HHS. A Memorandum of Agreement (MOA) between FHA and HHS outlines the duties and responsibilities of each agency in carrying out the Hospital Mortgage Insurance Program, including coordinated activities and tasks that FHA delegates to HHS.¹³ In accordance with this agreement, both FHA and HHS staff are involved with the screening of applicants during the preapplication meetings. FHA's policy is to include senior FHA staff and legal counsel, the account executive and client service team members (both of which can be either FHA or HHS staff), and engineering staff from HHS, among others, in such meetings.¹⁴ This policy helps insure that preapplication discussions with applicants are coordinated between FHA and HHS.

FHA and HHS also coordinate activities during the underwriting review portion of the application process, which is the process used by FHA to assess the risk of a potential loan to the GI/SRI fund. The nature of coordination at this level depends on the staffing of the account executive and client service team positions, since these positions can be filled by either FHA or HHS staff or a combination of both. The account executive and client service team are responsible for underwriting activities, including analysis of the market and financial feasibility of the project. In addition, HHS engineers review all design and construction aspects of the proposed project. Appendix II presents the roles and responsibilities of each agency in more detail.

FHA and HHS use regular meetings of the program management group to coordinate additional activities. This group, composed of senior FHA and HHS staff, meets weekly to assist account executives and client service teams as they review applications for mortgage insurance and monitor insured hospitals. Minutes of program management group meetings that we

¹³The MOA in effect during the period of our review covered fiscal years 2002 through 2005. A new Interagency Agreement became effective for fiscal years 2006-2010.

¹⁴For every hospital that applies to or is insured by the program, FHA designates an account executive to provide information about the program, assist the hospital, and monitor the hospital and its market.

reviewed show joint FHA and HHS discussion of new applications, as well as issues associated with the existing portfolio. According to investment bankers, hospital associations, consulting firms, and selected hospitals we spoke with, coordination between FHA and HHS is generally seamless.

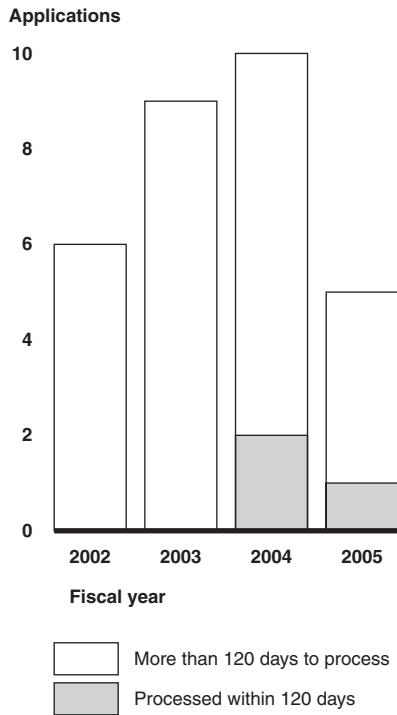
FHA Has Not Used Performance Measures to Manage the Program

The fiscal years' 2002-2005 MOA between FHA and HHS provides for FHA to establish performance measures and use them to evaluate tasks.¹⁵ While the MOA between FHA and HHS contains 22 performance measures, FHA has tracked actual performance for only 2 of these measures, 1 for processing complete applications within 120 days, and 1 for processing loan modification requests within 30 days. As a result, it is not possible to evaluate how well the agencies perform in implementing the program. According to FHA officials, the agency never intended to track these measures, or use them as actual measures of performance, but rather to show FHA's expectations of HHS. Neither HUD's fiscal year 2005 performance plan nor its performance and accountability report includes other performance measures for this program. Moreover, OMB did not assess this program as a part of its fiscal year 2005 Program Assessment Rating Tool (PART), which is used to assess the performance of federal programs. Appendix III provides more detailed information about the 22 performance measures contained in the MOA between FHA and HHS.

Analysis of the two performance measures for which data is collected shows that FHA is not meeting its performance goals for those measures. Based upon analysis of data from the Hospital Mortgage Insurance Management Information System, we determined that FHA did not meet its goal of processing 75 percent of hospital mortgage insurance applications within 120 days. Although the FHA received no more than 10 applications each year between fiscal years 2002 and 2005, FHA and HHS never processed more than 2 within 120 days (see fig. 1).

¹⁵Beginning in fiscal year 2006, HHS is responsible for delivering an annual report to FHA detailing its performance against each of the measures in the Interagency Agreement.

Figure 1: FHA Did Not Process Most Hospital Mortgage Insurance Applications within Targeted Time Frame



Source: GAO analysis of FHA's Hospital Mortgage Insurance Management Information System.

In addition, according to FHA, the agency did not meet its goal of processing at least 75 percent of loan modification requests within 30 days.¹⁶ However, analysis of available data shows that FHA and HHS improved from processing 45 percent of loan modification requests received in fiscal year 2002 within 30 days to processing 71 percent in fiscal year 2005.

FHA has not tracked other performance measures related to activities that are coordinated, or can be done, by both FHA and HHS staff. For example, according to one performance measure, hospitals with a weakening financial position should be identified early enough to allow time for the

¹⁶A loan modification refers to any action a hospital takes that requires HUD's consent under the terms of the Regulatory Agreement.

account executive to provide technical assistance and undertake default prevention measures. Since such hospitals are identified through the FHA's priority watch list system, these data are readily available for measurement. Similarly, another performance measure is designed to capture the soundness of analysis performed by client service teams, which can include both FHA and HHS staff, in assessing insurance applications. FHA has also not tracked this measure.

FHA also does not track performance measures of activities that it delegates to HHS. For example, one measure is designed to capture the number of complaints and compliments about HHS's timeliness, helpfulness, courtesy, and understanding. According to FHA, the agency has not tracked this or other measures because it has not had enough problems with HHS to warrant establishing a tracking system and that establishment of such a system would be both an administrative burden and a poor use of their resources. However, without collecting appropriate information, FHA cannot quantify the input it receives about HHS. In addition, FHA has not tracked performance measures related to construction design and monitoring, which HHS is responsible for. According to FHA, performance measures exist to indicate FHA's expectations of HHS's performance, even though HHS's performance is not tracked.

Several of the performance measures contained in the agreement between FHA and HHS lack the necessary characteristics of performance measures; that is, they are not measurable or objective. As a result, they do not provide useful information about the performance of the hospital program. For example, the measures related to the number of complaints and compliments about HHS are not measurable in that they do not specify a quantifiable threshold for expected performance. As a result, even if FHA tracked complaints, it is not possible to tell whether performance is meeting expectations. Other goals lack objectivity in that they require subjective judgment to assess program performance. As an example, one performance measure indicates that "plans and specifications do not need major revisions during the construction process because of significant architectural or engineering errors." Another indicator states that "preconstruction meetings are thorough and do not precipitate delays in application processing." In both cases, the performance measures require subjective judgment, because they do not make explicit what constitutes "major," "significant," or "thorough." As we have previously reported,

useful performance information is based upon measurable and objective performance measures.¹⁷ If useful performance information is collected, managers could use it to identify problems, try to identify the causes of problems, and/or to develop corrective actions.¹⁸ (App. III provides a complete list of the performance measures.)

While FHA does not track most of the performance measures outlined in the MOA, FHA's Hospital Mortgage Insurance Management Information System captures a significant amount of quantitative and qualitative data about the performance of the program, which could be incorporated into measurable and objective performance measures. This system captures key loan processing dates, financial performance data over time, and documentation of internal meetings and actions performed by both agencies to assist insured hospitals. Incorporation of this readily-available data into meaningful performance measures would enable FHA to better assess its management of the program.

FHA and HHS established a new interagency agreement covering fiscal years 2006 through 2010, which includes many of the same measures as the previous agreement, including those that are not measurable or objective. The new agreement also includes a requirement that HHS provide FHA with an annual report detailing its performance against each of the performance measures in the agreement. However, this interagency agreement does not specify whether and how FHA will track its own performance against the measures.

¹⁷GAO, *The Results Act: An Evaluator's Guide to Assessing Agency Annual Performance Plans*, [GAO/GGD-10.1.20](#) (Washington, D.C.: April 1998), 14.

¹⁸GAO, *Managing for Results: Enhancing Agency Use of Performance Information for Management and Decision Making*, [GAO-05-927](#) (Washington, D.C.: Sept. 9, 2005), 7.

Program Guidance Is Not Up to Date

FHA's primary guidance for its hospital mortgage insurance program has not been updated in over 20 years and does not reflect changes to the program over that time. As a result, this document does not contain current eligibility requirements, which may cause confusion for potential applicants. In 1973, FHA published the *Mortgage Insurance for Hospitals Handbook* and last updated the handbook in 1984. The purpose of the handbook is to provide complete information about the processing of hospital mortgage insurance, including basic program features and requirements, to hospitals, lenders, sponsors, FHA and HHS personnel, and all other interested parties. According to FHA, the Office of Insured Health Care Facilities has not had adequate staff to revise the handbook and is waiting for a proposed regulation to become final before revising it. Since the handbook has not been updated since 1984, it does not contain current eligibility requirements, policies, and processing procedures. As we have previously reported, internal control standards applicable to federal programs provide that information should be recorded and communicated in a timely manner.¹⁹

The handbook does not reflect key changes that the Hospital Mortgage Insurance Act of 2003 made to the program. This act revised the existing requirement that hospitals applying for FHA mortgage insurance have either a Certificate of Need or a state-commissioned study of market need; specifically, it provided that FHA would establish the means for determining market need and feasibility for hospitals.²⁰ In addition, the 2003 act exempted Critical Access Hospitals (CAH) from the requirement that at least 50 percent of care must be for general acute-care patients.²¹ According to one of the mortgage bankers that we met with, the handbook causes confusion because hospitals are uncertain about requirements applicable to them.

¹⁹GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999), 18.

²⁰A Certificate of Need is a state-issued designation of the market need for a hospital.

²¹CAHs, designated by states and HHS, are rural hospitals that, as of January 2004, may operate up to 25 beds for acute care and receive cost-based reimbursement from Medicare. CAHs were exempted from the requirement that no more than 50 percent of the total patient days during any year are customarily assignable to the categories of: chronic convalescent and rest, drug and alcoholic, epileptic, mentally deficient, mental, nervous and mental, or tuberculosis through July 31, 2006.

As we have previously reported, internal control standards provide that information, such as changes in eligibility requirements and application processing procedures, should be communicated in a timely manner. While FHA publicly communicates program changes through Mortgagee Letters, updating the Applicant's Guide, distributing copies of its minimum criteria for consideration, and updating its Web page, it has not incorporated all of this updated information into the program's handbook. All documentation, including the handbook, should be updated in a timely manner.²² Maintaining current documentation is an internal control that would benefit both those interested in the program and those that administer the program.

Potential Risks Exist Although FHA Has Mitigation Strategies in Place

The hospital program is a relatively small program within the broader GI/SRI fund and has a record of recovering claims. Despite its small size, both program and market trends show risks that could affect the hospital portfolio. FHA has mitigation strategies in place to address some risks but does not have a formal strategy to geographically diversify the hospital loan portfolio.

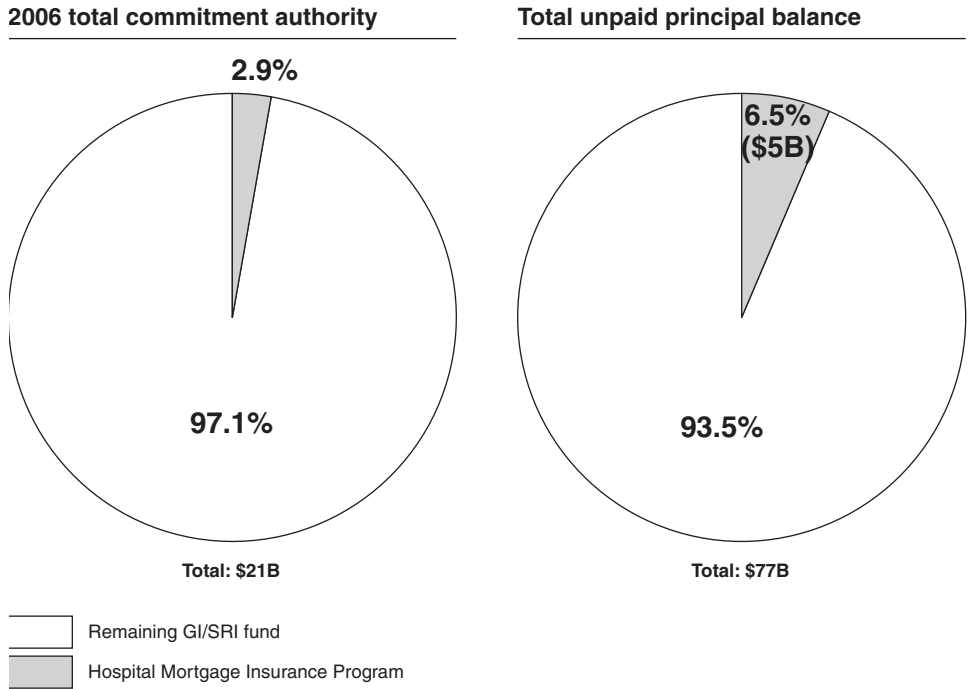
The Hospital Program Accounts for a Relatively Small Share of the Broader GI/SRI Fund, and Has Recovered a Majority of All Claims

The Hospital Mortgage Insurance Program comprises a relatively small part of the GI/SRI fund, representing about 2.9 percent of the GI/SRI's fund's fiscal year 2006 total commitment authority.²³ Moreover, the approximately \$5 billion in loans that FHA currently insures through the program is 6.5 percent of the \$77 billion in unpaid principal balance of the fund (see fig. 2). In addition to being a financially small component of the broader GI/SRI fund, the Hospital Mortgage Insurance Program has a record of recovering more than two-thirds of all historical claims, and lenders have not made a claim on an insured loan since 1999. Since the program's inception in 1968, there have been a total of 22 claims totaling \$225 million. Of this amount, FHA recovered 68 percent, or \$153 million.

²²FHA and HHS staffs compile updates to policies and procedures in an internal manual available only to FHA and HHS employees. According to FHA, this document is not meant to replace the *Mortgage Insurance Handbook for Hospitals*.

²³"Fiscal Year 2006 Federal Credit Supplement of the United States Government; Table 2—Loan Guarantees: Subsidy Rates, Commitments, and Average Loan Size" (Washington, D.C.: Office of Management and Budget, February 2005), http://www.gpoaccess.gov/usbudget/fy06/cr_supp.html (downloaded Oct. 6, 2005).

Figure 2: Hospital Mortgage Insurance Program Comprises a Relatively Small Part of the GI/SRI Fund



Source: GAO analysis of data on FHA's Hospital Mortgage Insurance Program.

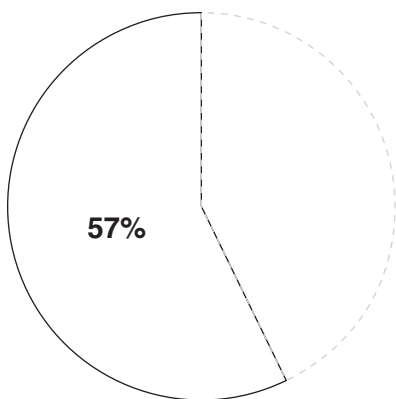
Loan Performance and Market Trends Reveal Sources of Potential Risks

In spite of the hospital program's relatively small size and the relatively good performance history of insured loans, analysis of both program and market trends shows risks that could affect the future performance of the hospital loan portfolio. For example, the average loan size insured through the program has varied over time but has been increasing from about \$26 million in 2002 to over \$122 million in 2005. This growth creates financial risk because a claim from one large loan could have a significant impact upon the program.

In addition, the majority of the currently insured loans in FHA's hospital portfolio are less than 10 years old. According to HUD, 70 percent of claims have historically occurred prior to a loan's tenth year. Currently, the loans that have been insured for less than 10 years have an aggregate unpaid principal balance of \$2.8 billion, representing about 57 percent of the aggregate unpaid principal balance (see fig. 3).²⁴

Figure 3: Proportion of FHA Hospital Loans That Have Been Insured Less Than 10 Years

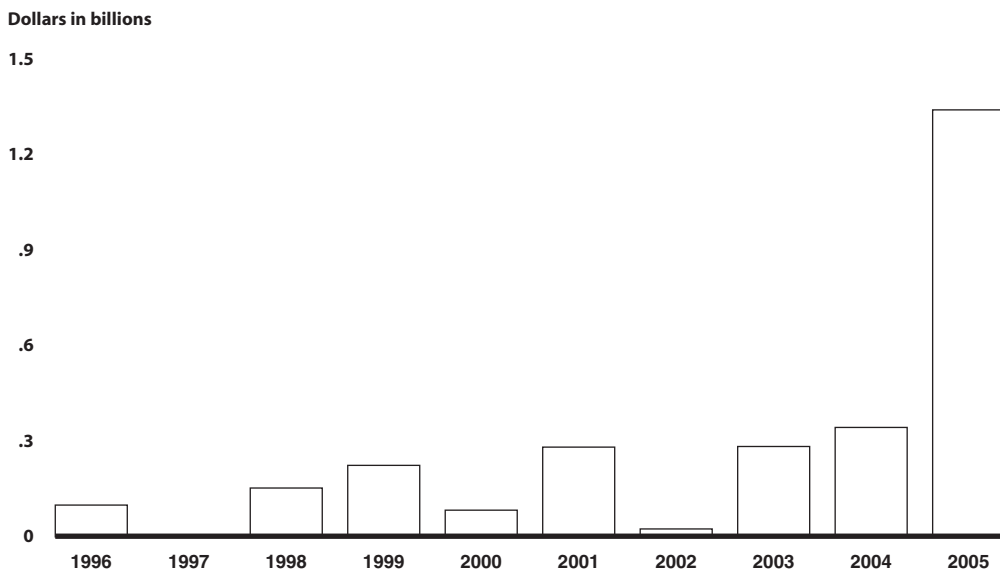
Proportion of all loans insured less than 10 years



Aggregate unpaid principal balance of loans insured for less than 10 years



Unpaid principal balance for loans insured less than 10 years



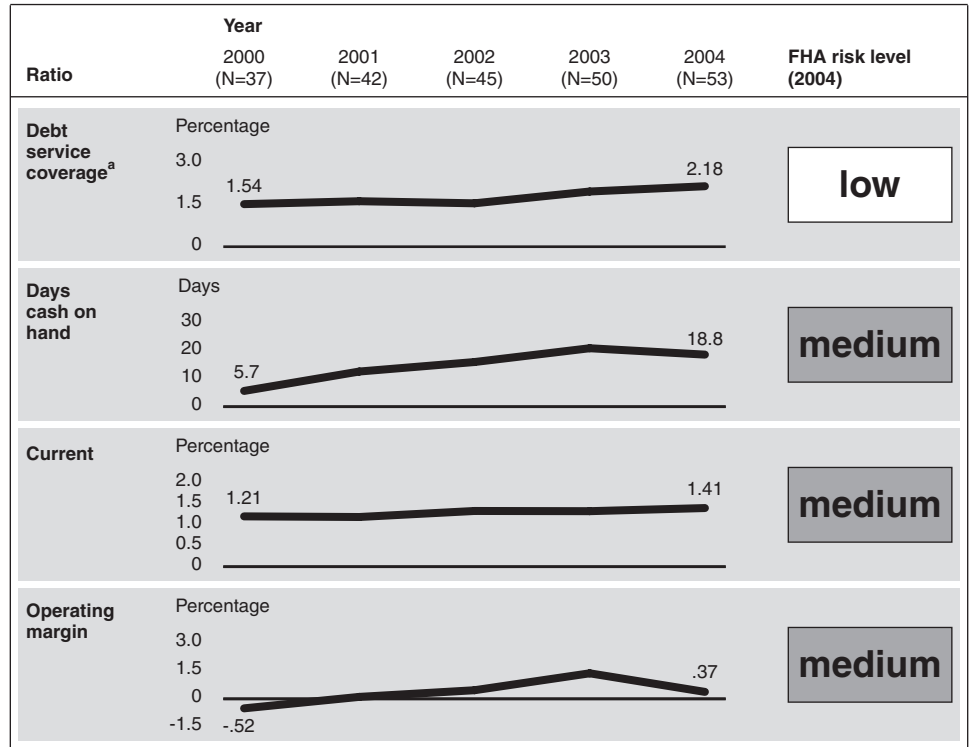
Source: GAO analysis of HUD's F47 database, a multifamily database.

²⁴This figure was calculated for all currently active FHA hospitals that had loans endorsed from 1996 through 2005.

Comparing FHA data on selected financial indicators with the criteria the agency uses to determine the financial health of program applicants shows some favorable trends but also indicates sources of potential financial risk (see fig. 4). Specifically, our analysis of program data for calendar years 2000 to 2004 shows that some insured hospitals increased their ability to meet their monthly and future mortgage payments. For example, the median debt-service coverage ratio, a measure of a hospital's ability to pay its mortgage with cash generated from current operations, increased from 1.54 to 2.18. While a value of 2.18 for this ratio indicates a low level of risk, according to FHA criteria, other financial indicators indicate medium levels of risk.²⁵ For example, the median number of days of cash on hand and the median current ratio (which compares a hospital's current assets to its current liabilities) both improved, yet still indicate a medium level of risk to the program. Finally, the median operating margin, which is indicative of a hospital's ability to control costs and expenses, improved between 2000 and 2004, yet indicates a medium level of risk based on FHA's criteria.

²⁵Financial ratios for active hospitals were compared with FHA criteria used to determine financial health of program applicants listed in the underwriting guidelines in the hospital insurance manual.

Figure 4: Selected Median Financial Indicators Show Varying Levels of Risk



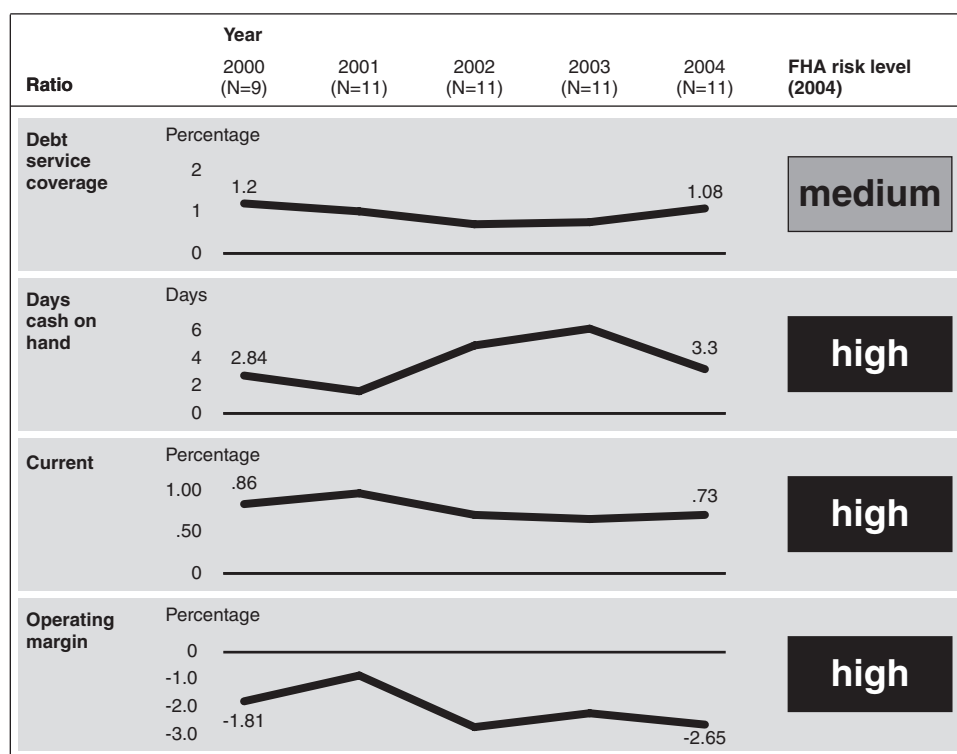
Sources: GAO analysis of FHA's Hospital Mortgage Insurance Management Information System and FHA applicant risk levels in hospital mortgage "Underwriting Guidelines" (hospital insurance manual).

^aThe N for debt-service coverage ratio differs slightly. It is 36 in 2000, 41 in 2001, 42 in 2002, 44 in 2003, and 49 in 2004.

Median financial indicators for the 11 hospitals that FHA has placed on its priority watch list show much greater levels of risk when compared with FHA's underwriting guidelines (see fig. 5). For these hospitals, performance as measured by all four selected indicators declined from 2000 to 2004. Further, in 2004, three indicators showed a high level of risk, based on FHA's criteria. For example, according to FHA's criteria, an applicant with an operating margin of less than zero is considered high risk. The hospitals on FHA's priority watch list had median operating margin of -2.65 in 2004. Similarly, according to FHA's criteria, an applicant with less than 15 days of cash on hand is also high risk, and hospitals on the priority watch list had a median of 3.3 days of cash on hand in 2004. FHA recognizes that the high risk levels of these selected financial indicators are among the reasons that

these hospitals are on its priority watch list and are, therefore, subject to closer monitoring to reduce the risk of a claim.

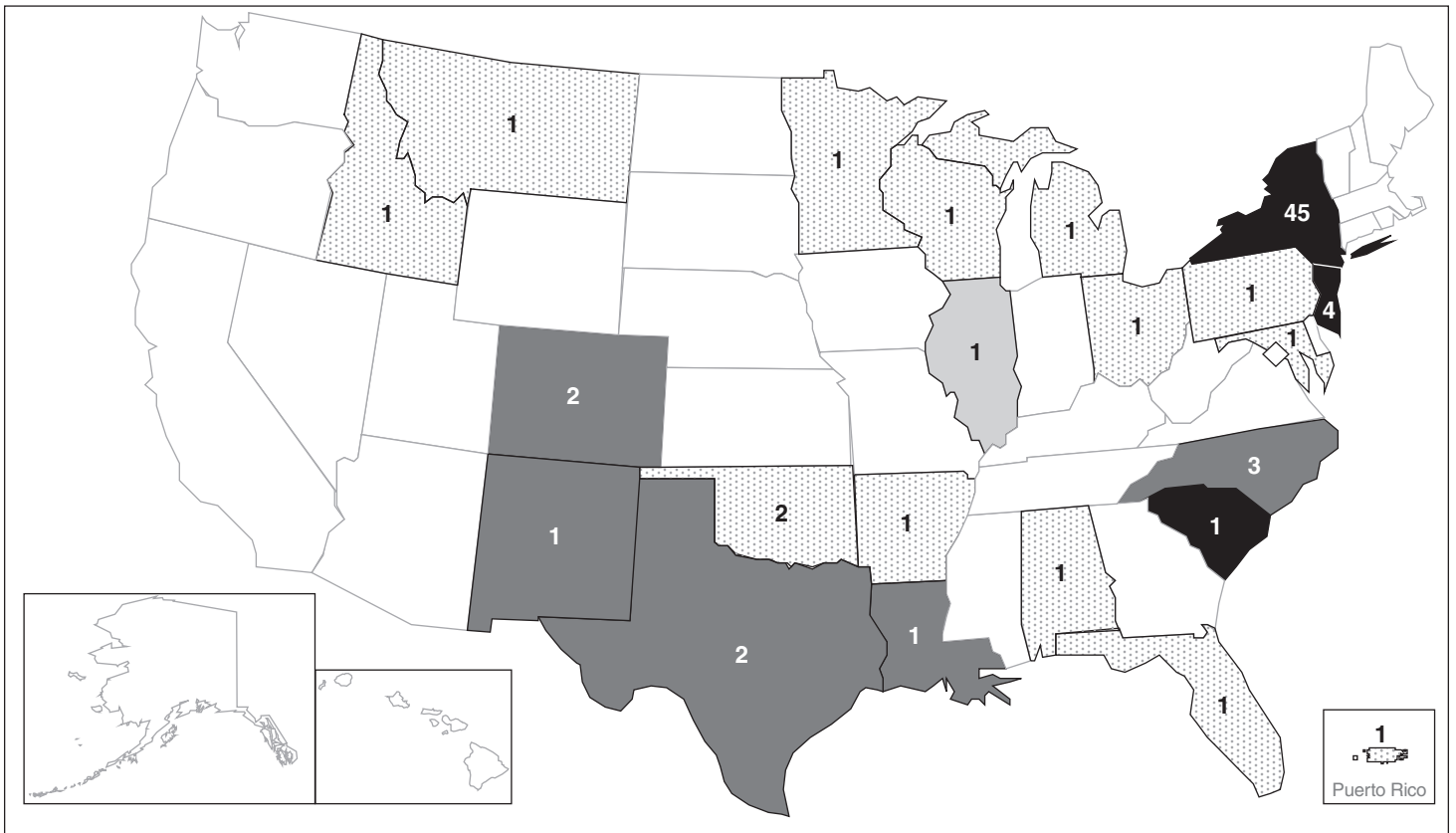
Figure 5: Selected Median Financial Indicators Show High Levels of Risk for Priority Watch List Hospitals








Sources: GAO analysis of FHA's Hospital Mortgage Insurance Management Information System and FHA applicant risk levels in hospital mortgage "Underwriting Guidelines" (hospital insurance manual).

Analysis of program data further shows that, while loans are increasingly being insured outside of the Northeast, the program is still concentrated in New York (see fig. 6). Though the percentage of the unpaid principal balance concentrated in New York has decreased from 89 percent in 2000, 61 percent of the unpaid principal balance in the program remains concentrated in New York in 2005. Of the 30 hospital loans that FHA has insured since 2000, 21 are outside of New York, and 19 are outside of the Northeast region. Since 2003, 5 of the loans insured were for CAHs.

Figure 6: FHA Loans Remain Concentrated in the Northeast as of December 2005: Active Loan Dollar Amount and Number of Loans by State



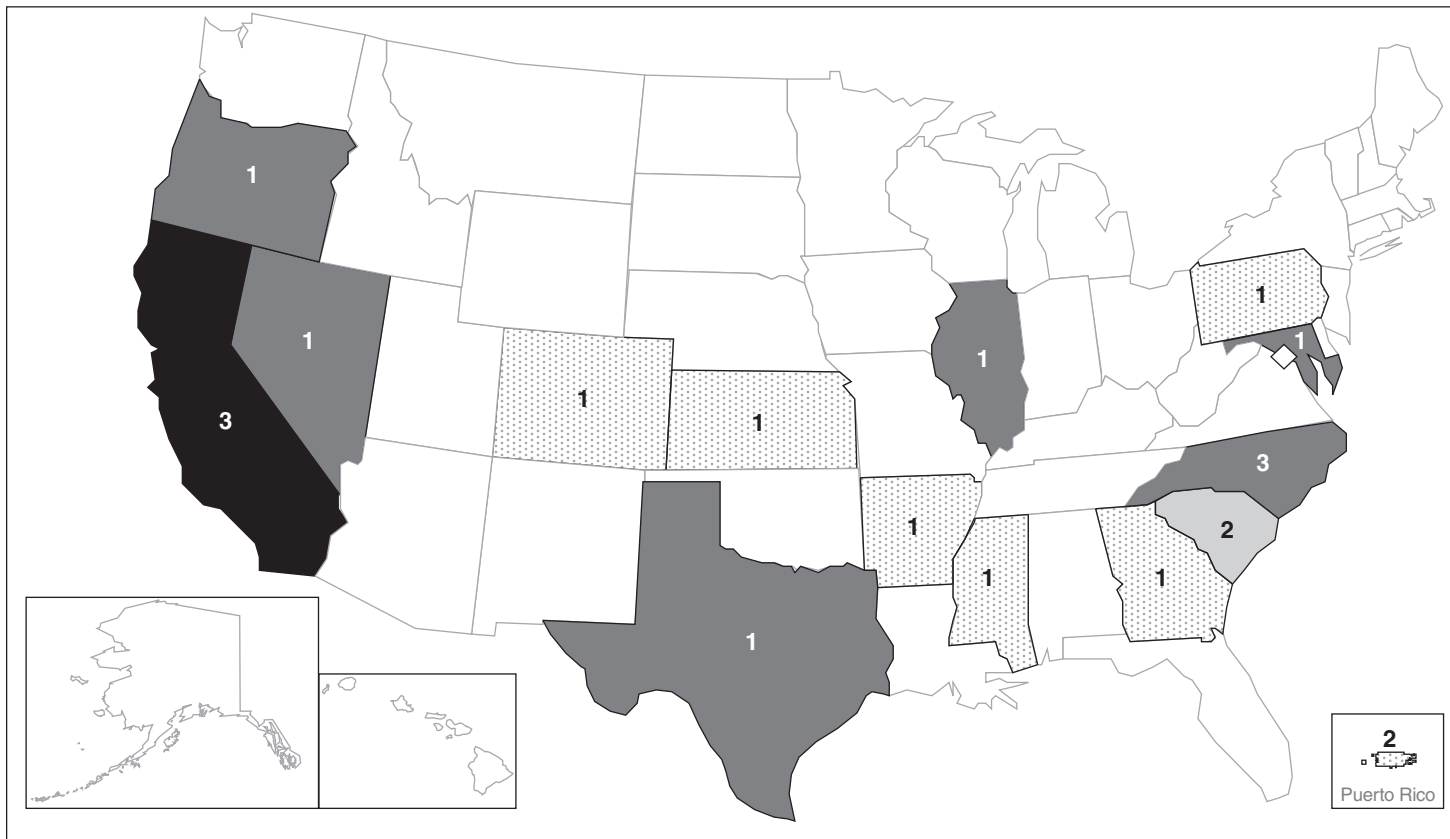
-  N/A (state has no active loans)
-  Less than \$50,000,000
-  \$50,000,000 - \$100,000,000
-  \$100,000,000 - \$300,000,000
-  More than \$300,000,000

Sources: GAO analysis of HUD's F47 database, a multifamily database (data); Art Explosion (map).

Further, 24 out of 25 mortgage insurance applications in development at the time of our study are located outside of the Northeast (see fig. 7).²⁶

²⁶ The 24 applications in development are those that HUD considers to be in the application pipeline. These include applications that are still under development and have not yet been received by HUD for review.

Figure 7: Applications for Hospital Mortgage Insurance are Geographically Dispersed as of December 2005: Application Dollar Amount and Number of Applications by State



- N/A (states without current program applicants)
- Less than \$50,000,000
- \$50,000,000 - \$100,000,000
- \$100,000,000 - \$300,000,000
- More than \$300,000,000

Sources: GAO analysis of FHA's Hospital Mortgage Insurance Management Information System (data); Art Explosion (map).

Despite these strides, the high concentration of the program's unpaid principal balance in New York, as well as concentrations with single borrowers with multiple loans, creates risks. New York hospitals insured through FHA, like hospitals nationwide, rely heavily upon reimbursement through Medicare and Medicaid.²⁷ Since a portion of Medicaid funding comes from states, any cuts made by the state of New York could have an especially negative impact on the hospital program. Insured hospitals in New York are also vulnerable to other state policies. For example, a task force appointed by the Governor is in the process of identifying New York hospitals for closure or restructuring. The Governor and state legislature have committed state funds to assist in restructuring efforts, and the state has had a history of helping its hospitals avoid defaults. Nevertheless, any recommendations for the closure or restructuring of FHA-insured hospitals may present the risk of an insurance claim. Further, some New York hospitals have multiple loans insured through the program, one with unpaid principal balances totaling approximately \$828 million as of December 2005. According to HUD's comments on the draft of this report, this hospital is a financially sound, well-endowed institution that poses a low risk of default.

Industry Trends Pose Risks to Hospitals, Including Those with FHA Insured Mortgages

The hospital program may also face risks from changes in the health care industry at large. According to industry literature, decreasing revenue streams, increases in the number of uninsured patients, increased competition from specialized facilities, and heightened capital needs are some of the trends that affect all hospitals, including FHA-insured hospitals.

²⁷According to Centers for Medicare & Medicaid Services (CMS) data, of the total patient discharges for insured New York hospitals, 21 percent were reimbursed by Medicaid and 29 percent by Medicare.

We and others have reported that Medicare and Medicaid spending may not be sustainable at current levels.²⁸ If program cuts occur in Medicaid, for example, states may take cost containment measures to reduce spending.²⁹ Such measures may include frozen, or reduced, reimbursement rates to providers and restrictions on eligibility for these programs.³⁰ In addition, the number of Medicare enrollees is projected to increase as baby-boomers age and become Medicare-eligible.³¹ These trends will affect all hospitals, including FHA-insured hospitals, which generally have Medicare and Medicaid patients in their payer mix. On average, Medicare discharges for FHA-insured hospitals represented 29 percent of total discharges per hospital, and Medicaid discharges represented 19 percent of total discharges per FHA-insured hospital.³² (See fig. 8 for Medicare and Medicaid discharges by state.) Stated another way, nearly 50 percent of the reimbursement that program hospitals receive is through Medicare and Medicaid.

²⁸GAO, *21st Century Health Care Challenges: Unsustainable Trends Necessitate Reforms to Control Spending and Improve Value* presented before the Citizens' Health Care Working Group, Salt Lake City, Utah, on July 22, 2005, 8.

²⁹Medicaid program cuts of \$4.8 billion over 5 years are included in the pending Deficit Reduction Omnibus Reconciliation Act of 2005 (S.1932). Should it be enacted, the act's provisions include increasing cost-sharing for Medicaid beneficiaries and allowing states to reduce benefits.

³⁰Fitch Ratings, *2005 Non-Profit Hospitals and Health Care Systems Forecast* (New York, NY: Jan. 20, 2005), 8.

³¹*Ibid.* According to the United States Bureau of the Census, baby boomers are those people born in the post-World War II period from 1946 through 1964.

³² The term discharge refers to the formal release of a patient by a hospital; this includes the termination of a period of hospitalization by disposition to a nursing home or home care. Medicare discharges refer to hospital reimbursement through Medicare, and Medicaid discharges refer to hospital reimbursement through Medicaid.

Figure 8: FHA-Insured Hospitals Have Medicare and Medicaid Payers among Their Patient Discharges

State	Percentage of discharges by type		Total hospital discharges
	Medicare	Medicaid	
Arkansas	46.53	9.65	2,435
Colorado	27.15	22.38	3,565
Florida	59.05	13.88	1,729
Idaho	65.31	9.09	539
Illinois	13.19	56.58	18,385
Maryland	34.59		3,865
Michigan	45.91	7.53	1,860
Minnesota	48.52	15.06	2,430
New Jersey	32.18	10.22	45,060
New Mexico	15.36	18.71	18,816
New York	29.17	20.66	571,034
North Carolina	47.03	27.21	11,026
Ohio	69.99	5.76	833
Puerto Rico	27.87	15.70	8,281
South Carolina	27.23	34.63	25,622
Texas	30.41	.52	63,521
Wisconsin	28.82	12.62	1,728

Source: GAO analysis of CMS hospital cost report database as of calendar year 2003.

Note: More than 90 percent of these data have undergone basic edit checks; however, Centers for Medicare & Medicaid Services (CMS) has not yet determined whether these data require an audit. These data may change as they undergo further review by CMS. In addition, CMS does not enforce dates by which hospitals must report data. Thus, only 49 of the 59 FHA hospitals active as of October 2005 had provided data for 2003.

Hospitals, including FHA-insured hospitals, must also contend with the rising number of underinsured and uninsured patients, which place demands on hospitals to provide care with little to no reimbursement. According to the U.S. Census Bureau, the number of uninsured persons rose from under 40 million people in 2000 to approximately 45 million people in 2003. This trend may pose a risk to the program. In addition, hospitals in New York, where the hospital mortgage insurance is concentrated, serve a high proportion of uninsured patients.

Credit rating agencies state that competition is increasing in the health care market as the type of care provided shifts to outpatient and specialty hospitals, which provide profitable services, such as cardiology, surgery, orthopedics, and diagnostic imaging.³³ Specialty facilities providing these services can take patients and revenue from general acute-care hospitals, which supplement revenue shortfalls with profitable services after providing needed, but unprofitable, services to the community. The growth of specialty hospitals, such as ambulatory surgery centers, is strong. The average number of specialty hospital openings has increased from 5 hospital openings in the 1960s to 27 hospital openings in the 2000-present time period.³⁴

Hospitals throughout the health care sector face increasing capital demands, yet many have limited access to capital according to hospital industry literature.³⁵ For example, hospitals face demand for outpatient services, emergency room upgrades, and technological advancements, which have significant up-front and maintenance costs. A reputable credit rating agency estimates that information technology expenditures now range between 20 to 30 percent of a hospital's capital budget. Financially weaker hospitals have less access to capital, yet often have pent-up capital needs. According to a recent rating agency report, New York hospitals have unmet capital needs as a result of their older infrastructure and because they are generally financially weaker than the average hospital.³⁶

³³Fitch Ratings, *2005 Non-Profit Hospitals and Health Care Systems Forecast* (New York, NY: Jan. 20, 2005), 6; Standard & Poors, *U.S. Not-For-Profit Health Care 2005 Median Ratios: Improvement Continues Across the Rating Spectrum* (New York, NY: July 20, 2005), 10; Moody's Investors Service, *Not-For-Profit Healthcare Sector: 2004 Industry Outlook* (New York, NY: January 2004), 9-10.

³⁴GAO, *Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served*, [GAO-03-683R](#) (Washington, D.C.: Apr. 18, 2003), 6.

³⁵Healthcare Financial Management Association, *Financing the Future Report 1: How are Hospitals Financing the Future? Access to Capital in Health Care Today* (Westchester, IL: 2003), 1; Moody's Investors Service, *Not-For-Profit Healthcare: Capital Access: Moody's Answers the Five Most Frequently Asked Questions on Capital Planning* (New York, NY: September 2004), 1.

³⁶Standard and Poor's, *New York Health Care: Low Hospital Ratings, Weak Access to Capital* (New York, NY: May 11, 2004), 1.

FHA Uses Tools to Mitigate Risk

FHA uses a variety of tools to mitigate risk in the hospital program. For example, during its preliminary assessment of a hospital, FHA reviews the hospital's ability to pay its mortgage by analyzing its debt service coverage ratio and determines if this ratio meets FHA's minimum requirement.³⁷ FHA takes other steps when reviewing applications (as discussed previously) designed to keep out excessively risky projects and also imposes requirements on insured hospitals to control risks. These include

- assessing the viability of projects at preapplication meetings with key hospital representatives;
- using a comprehensive underwriting process that assesses, among other factors, past and projected financial performance and the demand for the hospital's services;
- hiring an independent consultant to evaluate the feasibility of the proposed project and its potential risk to the FHA;
- requiring insured hospitals to establish a cash reserve fund sufficient to cover 2 years of mortgage payments;³⁸
- requiring insured hospitals to maintain compliance with key agreements between the hospital and FHA and monitoring these agreements;³⁹ and

³⁷While hospitals should meet certain criteria in terms of their debt-coverage ratio and other financial ratios, if the hospital cannot do so, but can demonstrate that its financial performance has been improving in recent years, it may still be considered by FHA for mortgage insurance.

³⁸The reserve fund may be used to pay debt service on the mortgage until the insurance proceeds or debenture payments are received from FHA. According to FHA guidelines, hospitals may borrow from this fund with FHA's permission.

³⁹When an insured hospital breaks a covenant, FHA requires the hospital to take corrective action so that the loan is in compliance with the covenant. For example, a hospital may be required to hire a consultant to help it identify and resolve the issues that led to its noncompliance.

-
- considering insured hospitals that fail to meet certain financial criteria for placement on the priority watch list.⁴⁰

FHA has also made some efforts to address the risks associated with the geographic concentration of the program in New York. Since 1999, FHA has had goals for geographically diversifying the hospital portfolio. Currently, FHA's goals for diversifying the portfolio include reviewing and processing applications for projects in states other than New York. While the agency does not have a formal strategy for marketing the program outside of New York, it has made some efforts to diversify the hospital portfolio by

- simplifying its application process for CAHs and providing rural hospital associations with information about the program;
- hiring an expert in rural hospitals;
- visiting hospital association conferences to educate members about the program; and
- educating HUD field attorneys, mortgage bankers, and consultants about the program.

HUD has also cooperated with requests for program information from the trade media and assisted other researchers, which resulted in the publication of articles and reports that provided information about the advantages of the hospital program in financing capital projects. A formal strategy, however, would provide the agency with a tool for comprehensively planning for and executing activities that would lead to the geographic diversification of the hospital portfolio. OMB guidance, for example, requires that agencies include a description of the means and strategies that will be used to achieve goals in their strategic plans. Such strategies could include, for example, the processes, skills, technologies, and various resources that will be used to achieve goals.

⁴⁰According to FHA policy, the following circumstances should be used as flags to trigger closer evaluation of a hospital's financial status: a missed principal or interest payment; significant losses from adverse revenue or expense trends over time, or a major one-time loss; poor liquidity; and a negative cash flow over debt service requirements.

HUD's Model for Estimating Credit Subsidy Costs Excludes Potentially Relevant Factors

HUD uses a model for estimating annual credit subsidies that does not explicitly consider the impacts of some potentially important factors. HUD's model incorporates factors and assumptions about how loans will perform, including estimated claim and recovery rates, which are consistent with OMB guidance. HUD has generally calculated a negative subsidy rate for the hospital program, meaning that estimated cash inflows have been greater than estimated cash outflows. However, HUD's model does not explicitly consider the potential impacts of prepayment penalties or restrictions when estimating prepayments, or the debt-service coverage ratios of hospitals at the time of loan origination.

For budgeting purposes, agencies that make loans and provide loan guarantees must estimate the costs to the government over the life of the loans that will be insured, commonly referred to as the subsidy cost. In order to estimate the subsidy cost of the Hospital Mortgage Insurance Program, HUD uses a cash-flow model to project expected net cash flows for all these loans over their entire life. HUD's model is a computer-based spreadsheet that uses assumptions based upon historical and projected data to estimate the amount and timing of claims, subsequent recoveries from these claims, as well as premiums and fees paid by the borrower. In addition, HUD does not consider prepayment penalties and restrictions when it estimates the level and timing of prepayments, which affect estimates of future claims and premiums.

HUD inputs its estimated cash flows into the OMB's credit subsidy calculator, which produces the official credit subsidy rate. A positive credit subsidy rate means that the present value of cash outflows is greater than inflows, and a negative credit subsidy rate means that the cash inflows are estimated to exceed cash outflows. For the hospital program, cash inflows include premiums and fees, servicing and repayment income from notes held in inventory, rental income from properties held in inventory, and sale income from notes and properties sold from inventory. Cash outflows include claim payments and expenses related to properties and notes held in inventory.

Since the hospital program's inception, FHA has paid a total of 22 hospital mortgage insurance claims. The last claim was filed in 1999. Because of the small number of claims, HUD determined that claim rates based solely upon the program's historical claims experience would not be reliable.⁴¹ As a result, HUD uses a methodology initially developed by OMB to increase its estimated claim rate by assuming that the lenders for some active hospitals would file claims for insurance. HUD refers to this methodology as an artificial default.⁴² In determining which loans to artificially default, HUD focuses on hospitals that generally have a higher risk of default, and are therefore on FHA's priority watch list.⁴³ According to OMB officials, the use of this artificial default accounts for the risk that exists due to the low number of large size loans insured, potential changes in Medicare or Medicaid reimbursement rates, and the geographic concentration of the program in New York, which make the program vulnerable to regional economic conditions.

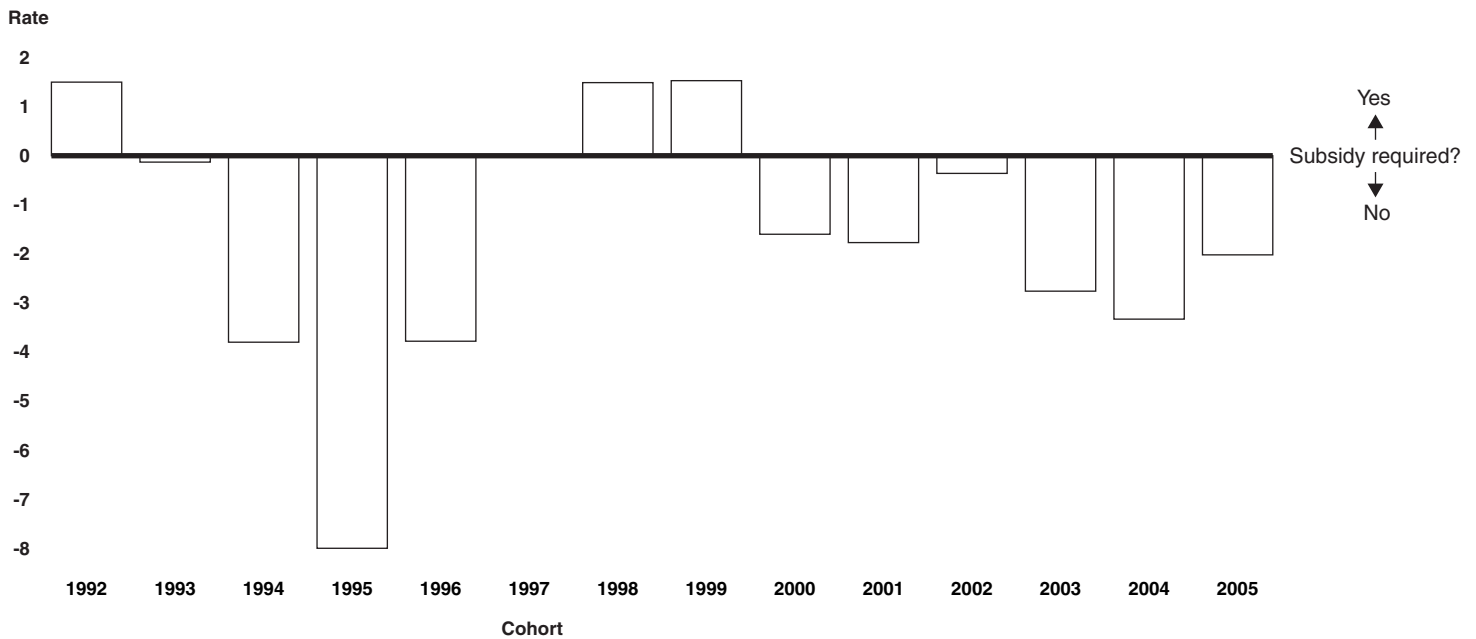
In 10 of the 14 years that HUD has been estimating the cost of the Hospital Mortgage Insurance Program under credit reform, HUD has estimated that the present value of cash inflows from fees, premiums, and recoveries from loans and properties sold would exceed the outflows from claim payments and other expenses related to properties and notes held in inventory. As a result, HUD calculated a negative credit subsidy rate for the hospital program for these 10 years. In the other 4 years, HUD estimated positive or no credit subsidy costs for the program. Figure 9 shows changes in the credit subsidy rate from 1992 to 2005.

⁴¹Three hundred forty-one loans have been insured over the life of the program, as of Dec. 31, 2005.

⁴²While the term "default" refers to the status of a loan when a mortgage payment is late and "claim" refers to the filing of a claim for insurance, HUD uses the term "artificial default methodology" to refer to its methodology for increasing the number of expected claims for insurance.

⁴³Inclusion on the priority watch list is based in part on financial criteria, including a current debt service coverage ratio of less than 1.10. This criterion serves as a flag but is not a determinant for inclusion on the priority watch list.

Figure 9: Credit Subsidy Rates for the Hospital Mortgage Insurance Program Have Generally Not Indicated a Need for Subsidies



Sources: GAO analysis of HUD data (1992-1993) and OMB federal credit supplement data (1994-2005).

While HUD’s model includes assumptions that are consistent with OMB guidance, such as assumptions on estimated claim and recovery rates and an artificial default methodology to supplement the claim experience, HUD’s model does not explicitly consider the potential impact of prepayment penalties or restrictions, even though they can influence the timing of prepayments and claims and collection of premiums. Inclusion of initial debt-service coverage ratios, as a factor predictive of defaults and claim rates into HUD’s cash-flow model for the hospital program, could potentially enhance HUD’s estimate of the subsidy cost of the program. According to some economic studies, prepayment penalties, or penalties associated with the payment of a loan before its maturity date, can

significantly affect borrowers' prepayment patterns.⁴⁴ In turn, prepayments affect claims because if a loan is prepaid it can no longer go to claim. According to FHA officials, FHA does not place prepayment penalties on FHA-insured hospital loans. However, according to the hospital program's regulations, a mortgage loan made by a lender that has obtained the funds for the loan through bonds can impose a prepayment penalty charge and place a prepayment restriction on the mortgage's term, amount, and conditions.⁴⁵

According to FHA officials and mortgage bankers, prepayment restrictions on hospital loans are generally in the form of 10-year restrictions on the prepayment of bonds. While FHA does not maintain data specifically on insured hospitals' bond-financing terms, prepayment restrictions are specified on the mortgage note, which is available to FHA. Moreover, according to the *Mortgage Insurance for Hospitals Handbook*, FHA has access to bond-financing terms because, upon completion of bond issues, applicants are required to submit bond-related documents to FHA so that FHA can verify that the fees, charges, and other costs previously approved with respect to debt restructuring. Incorporation of such data into the hospital program's credit subsidy rate model could refine HUD's credit subsidy estimate by enhancing the model's ability to account for estimated changes in cash flows as a result of prepayment restrictions.

According to HUD officials responsible for HUD's cash-flow model, prepayment penalties and restrictions are not incorporated into the model because HUD does not collect such data. HUD officials added that, even though the cash-flow model does not explicitly account for prepayment penalties and restrictions, its use of historic data implicitly captures trends that may occur as a result of prepayment penalties and restrictions. However, by not explicitly incorporating prepayment penalties or restrictions into the cash-flow model, HUD's model is less able to estimate the impact of changes in prepayment patterns of current and future cohorts.

⁴⁴Jesse M. Abraham and H. Scott Theobald, "A Simple Prepayment Model of Commercial Mortgages," *Journal of Housing Economics*, vol. 6, no. 1 (1997); Austin Kelly, V. Carlos Slawson, Jr., "Time-Varying Mortgage Prepayment Penalties," *Journal of Real Estate Finance and Economics*, vol. 23, no. 2 (2001); Qiang Fu, Michael LaCour-Little, and Kerry D. Vandell, "Commercial Mortgage Prepayments Under Heterogeneous Prepayment Penalty Structures," *The Journal of Real Estate Research* vol. 25, no. 3 (2003).

⁴⁵The regulations also state that prepayment restrictions and penalty charges must be acceptable to the FHA Commissioner.

HUD's cash-flow model also does not consider the initial debt-service coverage ratio of hospital loans at the point of loan origination. By initial debt-service coverage ratio, we are referring to the projected debt-service coverage ratio that is considered during loan underwriting. (HUD's cash-flow model does consider the *current* debt-service coverage ratio of insured hospitals through its artificial default methodology, which, as previously explained, includes hospitals that are on FHA's priority watch list. This list may include insured hospitals if, based upon the last available full year of data, their debt-service coverage ratio is below 1.10.)

According to the HUD official responsible for HUD's cash-flow model, the initial debt-service coverage ratio of a hospital at the point of loan origination is not included as a part of the cash-flow model for the hospital program because it (1) is not a cash flow, (2) does not vary, and (3) has no predictive value. We agree that a debt-service coverage ratio is not a cash flow. However, initial debt-service coverage ratios potentially *affect* relevant cash flows, as do other factors that are included in HUD's model but are also not cash flows, such as prepayments. For example, the model considers estimated prepayments because they potentially affect future cash inflows from fees and future cash outflows from claim payments. Initial debt-service coverage ratios are another important factor that may affect cash flows, as loans with lower initial debt-service coverage ratios may be more likely to default and result in a claim payment. They can also be used to assess the financial health of either an applicant or a hospital in the existing portfolio.

According to officials from FHA's Office of Insured Health Care Facilities, the projected debt-service coverage ratio is most meaningful for the third or fourth year projected, when construction is most likely to be complete. Our analysis of projected debt-service coverage ratios, which include the amount of new debt being insured, shows that these ratios varied from 1.48 to 3.11 during the fourth year projected.⁴⁶ All other factors being equal, loans with a debt-service coverage ratio of 3.11 are generally considered to have less risk than a loan with only a 1.48 debt-service coverage ratio.

Finally, we also found that economic studies show mixed results regarding the significance of the impact of debt-service coverage ratios upon commercial mortgage defaults. Some studies find initial debt-service

⁴⁶We analyzed projected debt-service coverage ratios from the underwriting reports of 13 hospitals that applied for mortgage insurance between 2002 and 2005.

coverage ratios to be statistically insignificant in modeling commercial mortgage defaults.⁴⁷ Other studies indicate that initial debt-service coverage ratios are meaningful factors in modeling default risk and are helpful in predicting commercial mortgage terminations.⁴⁸ Analysis of initial debt-service coverage ratio information, which is available in underwriting documents, may be used to identify trends or shifts in the overall risk of the portfolios that should be considered when making credit subsidy estimates. Further, current credit reform guidance calls for agencies to use the best available data when preparing their credit subsidy estimates.

Conclusions

The Hospital Mortgage Insurance Program plays an important role by insuring loans for capital improvements at hospitals that, due to their greater financial risks, would otherwise face difficulty in accessing capital. FHA's process for reviewing applications for mortgage insurance, while somewhat lengthier and involving more steps compared with those of private bond insurers, appears to be a reasonable response to the generally riskier nature of the applicants. Further, the agency's techniques for monitoring insured hospitals are quite similar to those used by private insurers, and the program has operated for several years without experiencing an insurance claim.

FHA and HHS appear to work together reasonably well in carrying out their respective roles in administering the program. However, it is difficult for us, FHA's managers, or the Congress to assess how well the agencies perform in implementing the program because FHA has not established a set of meaningful program performance measures or collected the information needed to assess performance. We have previously reported on the importance of agencies' collecting useful performance information.

⁴⁷Brian A. Ciochetti, Yongheng Deng, Bin Gao, and Rui Yao, "The Termination of Commercial Mortgage Contracts Through Prepayment and Default: A Proportional Hazard Approach with Competing Risks," *Real Estate Economics*; vol. 30, no. 4 (2002); Kerry D. Vandell, Walter Barnes, David Hartzell, Dennis Kraft, and William Wendt, "Commercial Mortgage Defaults: Proportional Hazards Estimation Using Individual Loan Histories," *Journal of the American Real Estate and Urban Economics Association*, vol. 21, no. 4 (1993).

⁴⁸Athanasios Episcopos, Andreas Pericli, and Jianxun Hu, "Commercial Mortgage Default: A Comparison of Logit with Radial Basis Function Networks," *Journal of Real Estate Finance and Economics* vol. 17, no. 2 (1998); Wayne R. Archer, Peter J. Elmer, David M. Harrison, and David C. Ling, "Determinants of Multifamily Mortgage Default," *Real Estate Economics*, vol. 30, no. 3 (2002).

If FHA collected useful performance information, such as information based on measurable and objective performance measures, the agency's managers could use it to identify problems, try to identify the causes of problems, and/or to develop corrective actions. Many program activities, including those delegated to HHS, are recorded in FHA's Hospital Mortgage Insurance Management Information System, and data from this system could be used to establish and monitor useful performance measures. In addition, because FHA has not updated the program handbook since 1984, hospitals, lenders, investment bankers, health care financing agencies, and other interested parties do not have ready access to a consolidated source of current program eligibility requirements, policies, and procedures. The lack of a consolidated source of current information may cause confusion and delay hospitals' ability to prepare applications that meet FHA's criteria. Further, outdated guidance in federal programs is an internal control weakness.

Although it represents a relatively small part of HUD's GI/SRI fund, the hospital program insures multimillion dollar loans that currently total nearly \$5 billion. The continued geographic concentration of insured hospitals in the state of New York poses a source of financial risk to the program. While this concentration has decreased from its high of 89 percent of outstanding insured principal balance in 2000, the current 61 percent represents a continuing concentration of credit risk. As a result, the program is vulnerable to New York State policies, such as the governor's call to restructure hospitals, as well as regional economic trends. While FHA has taken steps in the right direction, it does not have a formal strategy or plan for geographically diversifying the hospital portfolio, which could enhance current efforts to reach this goal.

HUD's cash-flow model used to estimate annual credit subsidy rates appears to be consistent with applicable OMB guidance; however, it does not explicitly take into account potentially useful factors such as prepayment penalties and restrictions or the initial debt-service coverage ratio of new loan cohorts. Although the program has not experienced a claim for insurance since 1999, the increasing size of loans insured, geographic concentration in New York and the Northeast, and other factors pose risks to the program. Including additional factors into HUD's model could potentially enhance the agency's estimates of the subsidy cost of the program, provide HUD and congressional decision makers with better cost data to assess the program, and help assure that the program adequately addresses financial risks.

Recommendations for Executive Action

To improve management of the Hospital Mortgage Insurance Program and reduce potential risks to the GI/SRI fund, we recommend that the Secretary of Housing and Urban Development direct the FHA Commissioner to take the following three actions:

- Establish measurable and objective performance measures for the hospital program and collect appropriate information to regularly assess performance against the measures.
- Update the program handbook to make publicly available current eligibility requirements, policies, and procedures.
- Develop a formal strategy to geographically diversify its portfolio of insured hospitals, including such elements as the processes, skills, technologies, and various resources that will be used to reach diversification goals.

To potentially improve HUD's estimates of the program's annual credit subsidy rate, we recommend that the Secretary of Housing and Urban Development explore the value of explicitly factoring additional information, such as prepayment penalties and restrictions, as well as the initial debt-service coverage ratio of hospitals, as they enter the program into its credit subsidy model.

Agency Comments and Our Evaluation

We provided a draft of this report to HUD and HHS for their review and comment. In written comments from HUD's Assistant Secretary for Housing—Federal Housing Commissioner, which incorporated comments from HHS, HUD concurred with our four recommendations. However, the agency disagreed with our presentation of certain aspects of the program, commenting that the report's "critique of procedural and technical matters" overshadowed the program's accomplishments. The Assistant Secretary's letter appears in appendix IV, and a letter from HHS appears in appendix V.

HUD expressed general agreement with the recommendations and noted actions that it plans to take. Specifically, the agency agreed

- to develop appropriate performance measures and implement data collection procedures to evaluate both program and contract administration;

-
- with the need to consolidate updated eligibility requirements, policies, and procedures into an updated handbook, and stated its intention to have the handbook finalized by the end of 2006;
 - to develop a formal strategy to geographically diversify its portfolio of insured hospitals, including such elements as the processes, skills, technologies, and various resources that will be used to reach diversification goals; and
 - to explore the value of explicitly factoring additional information, such as prepayment penalties and the initial debt-service coverage ratio of hospitals as they enter the program, during its annual review of cash flow modeling techniques for the hospital program.

In disagreeing with our presentation of FHA's efforts to diversify the hospital portfolio, HUD commented that diversification has been a top program goal for many years. Our draft report acknowledged that FHA has had goals for geographically diversifying the portfolio since 1999 and provided examples of FHA's diversification efforts. However, in response to the comments, we included additional examples of FHA's efforts. HUD also commented that the report does not appropriately emphasize the success that HUD and HHS have had in working together to implement the hospital program. Our draft report acknowledged the agencies coordinated involvement with key meetings, underwriting, and monitoring. Further, as the letter from HHS observes, our draft report concluded that the two agencies appear to be working reasonably well together. Because we believe the report accurately characterizes the relationship, we did not change it. Finally, HUD commented that the report infers that (1) it has not maintained current policies and procedures and (2) indicates that current eligibility requirements, policies, and procedures are unavailable to the public. Our draft report stated that the *handbook* does not contain current eligibility requirements, policies, or processing procedures, and acknowledged that FHA publicly communicates program changes through Mortgagee Letters. Nevertheless, in response to HUD's comments, we revised the report to include additional examples of FHA's efforts to communicate changes in eligibility requirements, policies, and procedures. We also continue to emphasize the value of updating all program documentation, including the handbook.

HUD also offered comments regarding the report's presentation of risks facing the hospital program, including potential cuts in reimbursement from Medicare and Medicaid, the potential for closures of hospitals in New

York stemming from a commission appointed by the Governor, and the large size of some loans. We recognize that potential cuts in reimbursement from the Medicare and Medicaid programs are a risk factor for hospitals in all states; however, New York is unique among states in accounting for over half of the hospital program's insurance portfolio. We revised the report to clarify that, due to this concentration, any cuts that the state of New York makes to its Medicaid program could have an especially negative impact. Regarding the New York Governor's commission, we are aware that state funds are available to assist in restructuring efforts, and that the Dormitory Authority of the State of New York is committed helping its hospitals avoid defaults. However, since there is no guarantee that FHA-insured hospitals will be protected, we continue to believe that a recommendation for their closure or restructuring may present the risk of an insurance claim. Finally, we revised the report as HUD suggested to note that the largest single exposure of \$828 million is for a hospital that, according to HUD, poses a low risk of default.

HUD commented that GAO's presentation of processing times for applications is misleading because it does not mention that there can be periods of time in which HUD cannot continue to process applications due to factors that applicants must address and are thus beyond HUD's control. Because HUD's system for tracking application processing times does not capture such periods of time, it is not possible for GAO to quantify their impact. Further, the report notes that processing times vary with the complexity of the project and may be affected by issues outside of HUD's control.

HUD took exception with our conclusion that it is difficult for us, FHA's managers, or the Congress to assess how well the agencies perform in implementing the program because FHA has not established a set of meaningful performance measures and stated a belief that program results indicate that the program is fulfilling its purpose. While our report acknowledges that the program has had a good performance history, the creation and use of performance measures can be used by agency managers to improve a program's results. As we note in the report, analysis of performance information helps managers identify problems, identify the causes of problems, and develop corrective actions. In addition, performance information can be used to develop strategies, identify priorities, make resource allocation decisions, and identify more effective approaches to program implementation.

HUD disagreed with our suggestion that it include such factors as initial debt-service coverage ratio into its credit subsidy modeling and noted that two of the studies that we cited found this ratio to be statistically insignificant in predicting commercial mortgage defaults. Our draft report in fact stated that economic studies have shown mixed results regarding the significance of the impact of debt-service coverage ratios on commercial mortgage defaults. However, we revised the report to explicitly footnote studies that show initial debt-service coverage ratios to be statistically insignificant and those that indicate that this ratio is a meaningful factor in modeling default risk. We also note that the two studies that found initial debt-service coverage ratios to be statistically insignificant were both based on the same, small data set. We acknowledge that HUD's cash-flow model considers the current debt-service coverage ratio of insured hospitals through its artificial default methodology. However, our recommendation is to include the debt-service coverage ratios at origination, so that the risk of loans at origination will be reflected in the credit subsidy rates for the cohort.

Finally, our draft report stated that FHA estimates that hospital loans are most likely to experience a claim during their tenth insured year. In its comment, HUD stated that historically 70 percent of claims occurred prior to a loan's tenth year. The statement in our draft report was based on actual historical conditional claim rate data. HUD subsequently provided additional information, which explained that the conditional claim rate peaked due to a single claim with multiple notes. As a result, we revised the report to reflect additional information.

We are sending copies of this report to the Secretaries of the Departments of Housing and Urban Development (HUD) and Health and Human Services (HHS). We also will make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report or need additional information, please contact me at (202) 512-8678 or woodd@gao.gov. Contact points for our Offices of Congressional Relations or Public Affairs may be found on the last page of this report. GAO staff who made major contributions to the report are listed in appendix VI.

David G. Wood

David G. Wood, Director
Financial Markets and Community Investment

Objectives, Scope, and Methodology

Our objectives were to review (1) the design and management of the program, as compared with private insurance; (2) the nature and management of the relationship between the Department of Housing and Urban Development (HUD) and the Department of Health and Human Services (HHS) in implementing the program; (3) the financial implications of the program to the General Insurance/Special Risk Insurance (GI/SRI) fund, including risk posed by program and market trends; and (4) how HUD estimates the annual credit subsidy for the program, including the factors and assumptions used.

To review the design and management of the Hospital Mortgage Insurance Program we interviewed officials at both the Federal Housing Administration's (FHA) Office of Insured Health Care Facilities and the Division of Facilities and Loans within HHS' Health Resources and Services Administration, and reviewed program policies, documentation of application processes, laws, and regulations. To compare the program's design with that of private insurers, we met with private bond insurers and the Association of Financial Guaranty Insurers, credit rating agencies, mortgage and investment banking firms, hospital associations, and state health care financing agencies in New York and New Jersey.¹

To describe how FHA and HHS coordinate the implementation of the hospital program, we interviewed FHA and HHS officials about the responsibilities for each agency in implementing the program. We also reviewed the Memorandum of Agreement between FHA and HHS that describes the division of duties and responsibilities between the two agencies and organizational charts that depict FHA's organization, HHS's organization, and the FHA-HHS interrelationship in program administration. We analyzed the extent to which performance measures related to interagency coordination were met by obtaining available data from FHA and analyzing time frames for processing applications and loan modification requests from the Hospital Mortgage Insurance Management Information System (HMIMIS). We compared performance measures with our criteria on performance measures and compared performance measures in the 2002-2005 Memorandum of Agreement with the performance measures in the 2006-2010 Interagency Agreement between FHA and HHS to identify any changes.

¹The Association of Financial Guaranty Insurers is the trade association representing 11 insurers and reinsurers of municipal bonds and asset-backed securities.

To identify the financial implications of the program to the GI/SRI fund, we interviewed and obtained documentation from FHA and HHS program officials and analyzed FHA data on program portfolio characteristics, including number and amount of loans by cohort, current insurance-in-force, and geographic concentration of loans, claims, and recoveries. Specifically,

- To obtain the number and amount of active and terminated loans, we created a report from the HMIMIS database, which is updated monthly. To assess the reliability of the HMIMIS data, we reviewed relevant documentation, interviewed agency officials who worked with this database, and conducted electronic testing of the data, including frequency and distribution analyses. We determined the data to be sufficiently reliable to obtain the number and amount of active loans. We corroborated these data with the FHA's 2004 report to the Congress.² As of December 2005, the administrators provided data from HUD's F-47 database, a multifamily database, to show (1) that there were 59 active hospitals with 74 active loans in the Hospital Mortgage Insurance portfolio and (2) that there had been 341 loans in the portfolio since the inception of the program. To assess the reliability of data from HUD's F-47 database, we reviewed HUD's Hospital Mortgage Insurance Program Functional Requirements Document, Procedures for Maintaining Group Records, and other relevant documentation, interviewed agency officials who worked with this database, and conducted electronic testing of the data, including frequency and distribution analyses. Our assessment showed that two loan records were lacking state data, and one record was lacking hospital name data but were identified by a unique project number. FHA administrators verified that these loans were endorsed long before electronic loan records were maintained and that they were unable to provide additional information. None of our analyses utilized the missing data elements for the two projects; therefore, there was no impact on this report. We determined the data to be sufficiently reliable to describe the geographic concentration of loans in the program.
- To determine the proportion of the Hospital Mortgage Insurance Program to the larger GI/SRI fund, we reviewed a spreadsheet provided

²Assistant Secretary for Housing—Federal Housing Commissioner, Department of Housing and Urban Development, Report to the Committees on Appropriations on the Section 242 program, Aug. 12, 2004.

by HUD's Office of Evaluation dated June 2005 on insurance-in-force for the hospital program to that of the GI/SRI fund.

- To determine the risk posed by insurance claims to the Hospital Mortgage Insurance Program, we analyzed spreadsheets with historic claims and recoveries data provided by HUD's Office of Evaluation and dated August 2005.
- To determine the geographic concentration of loans and loan prepayment history in the program, we analyzed data current as of December 31, 2005, in an extract of HUD's F-47 database. While we obtained extracts from HUD's F-47 database in April 2005, October 2005, and December 2005, all analyses from F-47 data in the report utilize the December 2005 extract only.

We also compared data on four financial ratios including debt service coverage, days cash on hand, current, and operating margin ratios provided from HMIMIS, current as of December 2005, with applicant criteria stated in the *Manual of the Hospital Insurance Program*.

To determine how FHA manages program risks, we interviewed FHA and HHS program officials and reviewed the *Mortgage Insurance for Hospitals Handbook* and manual to determine steps taken by the agency during the application and monitoring phases of the insurance process. We analyzed cash inflows to the program from income from notes held in inventory, rental income from properties held in inventory, sales income from notes, and properties sold from inventory. We also reviewed documentation of cash outflows, such as claim payments and expenses related to properties and notes held in inventory. To assess risk based on geographic concentration, we identified the state with the highest unpaid principal balance insured by the program. Finally, to assess risk posed by the geographic concentration of the program's unpaid principal balance, we extracted 2003 data from the Centers for Medicare & Medicaid Services (CMS) database on Hospital Mortgage Insurance Program hospitals active in 2005. We used CMS data to identify the number of discharged patients whose services were paid for through the Medicare/Medicaid programs from hospitals that have loans insured through the program. More than 90 percent of these data have undergone basic edit checks; however, CMS has not yet determined whether these data require an audit. These data may change as they undergo further review by CMS. In addition, CMS does not enforce dates by which hospitals must report data. Thus, at the time of this report, only 49 of the 59 active FHA hospitals had provided data for 2003.

We conducted a literature review and interviewed numerous officials of rating agencies and hospital associations to obtain information on risks due to health care market trends. We conducted the following academic literature searches: (1) Google's Scholar search engine using the terms "hospital mortgage insurance," "nursing home mortgage insurance," "hospital and default and FHA," "nursing home and default and FHA"; (2) PubMed Web site using the terms "hospital mortgage insurance" and "nursing home mortgage insurance;" and (3) HUDuser.org Web site using the terms "hospital mortgage insurance," "nursing home mortgage insurance," and "Section 242." We also searched for Inspectors General and agency reports through HUD and HHS Web sites using the terms "Hospital mortgage insurance" and "Section 242." Finally, we conducted a search on our internal Web site to identify previous work on the Section 242 program. The terms "hospital," "mortgage insurance," and "Section 242" were used for the period of January 1995 through March 2005.

To determine how HUD estimates the annual credit subsidy rate for the program, we interviewed program officials from HUD's Office of Evaluation and program auditors from the Office of Management and Budget (OMB), reviewed documentation of HUD's credit subsidy estimation procedures, and reviewed the cash-flow model for the program. We also compared the assumptions used in HUD's cash-flow model with relevant OMB guidance and reviewed economic literature on modeling defaults to identify factors that are important for estimation. Additionally, we analyzed data provided by FHA on program hospitals' projected debt-service coverage ratios (at the time of their loan application). HUD's Budget Office provided the program's annual credit subsidy rates for 1992 and 1993, and we obtained this rate for years 1994-2005 from the Federal Credit Supplement of the United States Budget.³

Our review did not include an evaluation of underwriting criteria, construction monitoring, or the need for the program. We conducted our work in Albany, New York; Chicago, Illinois; New York, New York; Paterson, New Jersey; Rockville, Maryland; and Washington, D.C., between February 2005 and January 2006 in accordance with generally accepted government auditing standards.

³For the years 1992 and 1993, the credit subsidy rate for the Hospital Mortgage Insurance Program was not reported in the Federal Credit Supplement.

FHA and HHS' Responsibilities in FHA's Hospital Mortgage Insurance Program Loan Cycle

Development	Department of Health and Human Services (HHS)	Federal Housing Administration (FHA)
Conduct preliminary review of hospital proposed for insurance.		x
Provide applicant guidance and feedback (including preapplication conference).	x	x
Conduct initial site visit to hospital.	x	x
Review and approve construction plans, specifications, and contracts.	x	
Engage independent feasibility consultant.		x
Account Executive and review team recommend approval or disapproval to the Program Management Group (PMG). ^a	x	x
PMG recommends approval or disapproval to the FHA management. ^b	x	x
FHA management recommends approval or disapproval to the FHA Commissioner.		x
FHA Commissioner makes final decision on whether to insure.		x
Make final underwriting determinations, conduct any needed legal reviews, issue firm commitment, close, and initially endorse loan.		x
Conduct preconstruction conference, monitor construction work, and process requests for advances of mortgage proceeds.	x	
Review cost certification, inform lender of maximum insurable mortgage amount, and process final advance.	x	
Arrange final closing and finally endorse mortgage.		x
Loan management		
Account Executive monitors hospital's performance by periodically reviewing financial and utilization data.	x	x
Account Executive will receive, review, and recommend to FHA management approval or disapproval of special requests and loan modifications (for example, partial release of security, transfer of physical assets, bond refundings, or major capital projects)	x	x
Approve or disapprove special requests and loan modifications.		x
Develop and carry out strategies for helping a troubled hospital improve its financial condition and for preventing or curing defaults.	x	x
Engage consultant to review finances and operations of a troubled hospital and to make recommendations for a financial turnaround plan.		x
Review quality and condition of insured hospital loan portfolio.		x
Determine the amount of liability for loan guarantees and credit subsidy rates.		x
Assignment		
Receive/process assignment of loan and pay insurance claim.		x
Review assigned hospital's operational performance and financial condition and conduct site visits as needed.	x	x

**Appendix II
FHA and HHS' Responsibilities in FHA's
Hospital Mortgage Insurance Program Loan
Cycle**

(Continued From Previous Page)

Development	Department of Health and Human Services (HHS)	Federal Housing Administration (FHA)
Account Executives receive, review, and recommend to FHA management approval or disapproval of proposed workout agreements, mortgage modifications, or note sales.	x	x
Bill for and collect mortgage payments.		x
Disposition		
Analyze hospital's situation, evaluate alternative uses, secure appraisal, make decision to foreclose, and arrange and hold foreclosure sale.		x
Contract for management services and repairs, as needed, to protect asset if FHA is mortgagee-in-possession or acquires hospital through foreclosure or deed-in-lieu.		x
Develop marketing plan, advertise, and sell hospital.		x

Source: FHA Hospital Mortgage Insurance Program staff.

^aThe Account Executive can be an FHA or HHS staff member. The review team, or Client Service Team, can consist of FHA and/or HHS staff. The PMG consists of both senior FHA and HHS staff.

^bFHA's Director of the Office of Insured Health Care Facilities.

FHA Assessed Performance Using 2 of 22 Performance Measures Included in the 2002-2005 Memorandum of Agreement

Performance measure	Coordinated task	Task delegated to the Department of Health and Human Services (HHS)	Measured by the Federal Housing Administration (FHA)?
Number of complaints from customers about the HHS staff's lack of helpfulness, timeliness, courtesy, understanding, etc. Number of compliments received for HHS staff's helpfulness, timeliness, courtesy, understanding, etc.		x	no
Preliminary information is provided within 2 business days of inquiry.	x		no
Time from receipt of complete application to decision letter. Process 75% of complete applications within 120 days of receipt.	x		yes
There are no instances of incomplete applications being received because applicant was not informed of application requirements.	x		no
Soundness of analysis. HUD may consider the following evidence that the team's analysis was flawed: (1) deterioration, within 2 yrs of the recommendation for approval, of the financial condition of an approved applicant due to conditions that should have been detected in the review, or (2) the ability of a disapproved applicant to subsequently obtain insurance elsewhere on similar terms and conditions within 6 months of the recommendation for disapproval.	x		no
Plans and specifications do not need major revisions during the construction process because of significant architectural or engineering errors or omissions made prior to or during the application process.		x	no
Problems do not arise during the construction period because of significant inconsistencies between contract documents.		x	no
Preconstruction meetings are thorough and do not precipitate delays in application processing for our customers.		x	no
Monthly inspection reports support the items and amounts included in monthly draws.		x	no
Change orders are documented and recommendations are supportable.		x	no
Length of time between the team's receipt of monthly requisition package and submission of the team's analysis and payment recommendation to HUD.		x	no
Hospital construction project is completed on time and within budget, unless mitigating factors outside HHS's control prevent this from happening.		x	no

**Appendix III
FHA Assessed Performance Using 2 of 22
Performance Measures Included in the 2002-
2005 Memorandum of Agreement**

(Continued From Previous Page)

Performance measure	Coordinated task	Task delegated to the Department of Health and Human Services (HHS)	Measured by the Federal Housing Administration (FHA)?
Length of time between completion of construction and recommendation for final endorsement. HHS accomplishes all activities in a timely manner and provides assistance and works with the hospital and contractor so as to minimize the length of time between completion of construction and recommendations for final endorsement.		x	no
Final recommendation package is complete, documented, and supportable if any issues or challenges are raised in relation to the construction phase of the project.	x		no
Customers with a weakening financial position should be identified early enough to allow time for the Account Executive (AE) to provide technical assistance and undertake default prevention measures before a situation becomes an emergency.	x		no
Each AE will develop and maintain a file in HHS's office on each customer with all pertinent information needed to evaluate the customer's condition.	x		no
AE's should not be "blindsided" by local, state, and national developments that affect the viability of customers.	x		no
Each customer meeting the conditions above for inclusion on the Priority Watch List (PWL) should be included on the PWL reports provided to HUD.	x		no
HHS's work should assist HUD's goal of zero claim payments.	x		no
Time from receipt of request to recommendation to HUD. Performance target is to process at least 75% of complete loan modification requests within 30 days of receipt.	x		yes
"Same as for insured loans."	x		no
HHS provides effective services to reduce or contain costs to the FHA insurance fund for the following activities: (1) transition into the HUD inventory; (2) stabilization of the hospital including patient, physical, and financial concerns; (3) marketing; and (4) disposition.		x	no

Source: HHS, Office of Special Programs, *Memorandum of Agreement between the Department of Housing and Urban Development (HUD) and the Department of Health and Human Services (HHS)*, 2001.

Note: Some performance measures refer to tasks that can be done by either FHA or HHS officials, which we refer to as "coordinated tasks." Other performance measures apply to tasks specifically for HHS, which we refer to as "HHS-delegated tasks."

Comments from the Department of Housing and Urban Development



U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
WASHINGTON, DC 20410-8000

FEB - 9 2006

ASSISTANT SECRETARY FOR HOUSING-
FEDERAL HOUSING COMMISSIONER

David G. Wood, Director
Financial Markets and Community Investment
United States Government Accountability Office
441 G Street, NW
Washington, DC 20548

Re: Draft report - Hospital Mortgage Insurance Program

Dear Mr. Wood:

This responds to Ms. Lisa Moore's letter of January 23, 2006, to US Department of Housing and Urban Development (HUD) Secretary Alphonso Jackson, requesting comments on GAO's draft report on the Hospital Mortgage Insurance Program. At the request of US Department of Health and Human Services (HHS) Secretary Michael O. Leavitt, comments from HHS have been incorporated into this response.

I would like to thank you for the positive comments on the program and the helpful suggestions that are included in the report. However, as discussed below, we believe that the report could place more emphasis on what HUD has accomplished since the GAO last reviewed the program in February 1996. The report's critique of procedural and technical matters is allowed to overshadow the program's very real accomplishments:

- The geographic concentration of HUD's portfolio of insured hospital mortgages in New York State has been reduced from 89 percent in 2000 to 61 percent today, through an aggressive outreach and diversification effort. Further reductions will occur as HUD processes the pipeline of new loan applications. Diversification is occurring because HUD has pursued a multifaceted marketing strategy that includes presenting program information at a variety of hospital industry forums, providing training to mortgage lenders in various regions, adapting program requirements to the needs of Critical Access Hospitals, permitting physician-owned hospitals that comply with regulations governing self-referrals to use the program, streamlining procedures to reduce processing times and increase user-friendliness, and providing program information to national and regional publications.
- In the last ten years, FHA has insured an additional 49 hospital mortgages. This has provided \$3.5 billion in needed capital financing to finance the construction and improvements of hospitals in 21 states, including 5 critical access hospitals serving rural areas and facilities in inner cities and other economically distressed areas. This not only provides valuable employment opportunities, but improves health care for generally underserved populations.

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- The FHA's hospital program has incurred only one claim out of 149 mortgages at risk during the past ten years. This was accomplished despite the fact that the program makes credit available to hospitals that pose a financial risk greater than those served by private insurance.
- Although HUD is accountable, it has worked in partnership with the Department of Health and Human Services to streamline and make more effective the review of loan applications. It has also strengthened the management of the portfolio of insured loans to avoid mortgage defaults, including offering comprehensive and intensive assistance to financially weak hospitals. To make this possible, HUD has expanded the Office of Insured Health Care Facilities from five to eleven staff members with extensive experience in hospital finance and management and will soon add a twelfth staff member.

We believe these improvements merit a careful assessment and evaluation in terms of program and risk management as directed in the Appropriations Committee report.

Critiques of Process Overshadow Program Results

While the draft report mentions the diversification statistics, I am concerned that its tone and substance fail to recognize what HUD has accomplished and continues to accomplish. For example, in the section "Results in Brief" the report states: "While FHA has goals to diversify the hospital insurance portfolio, and has made some efforts to do so, it does not have a formal strategy to achieve these goals." In fact, FHA has made more than "some efforts" toward diversification. Diversification has been a top program goal for many years, as evidenced in documents provided to your reviewers. The statistics show that diversification is occurring steadily. However, the draft report's emphasis on the absence of a formal written strategy overshadows FHA's real accomplishments.

Likewise, the draft report criticizes FHA for having performance measures in its interagency agreement with HHS that are not quantifiable or that are not measured on a regular basis. While this critique may be valid, it is allowed to overshadow the success that HUD and HHS have had in creating a "hand in glove" relationship that is unusual for two cabinet-level agencies with different priorities and cultures. The report does state in the section titled "Agencies Coordinate Key Activities, but FHA Does Not Track Most Performance Measures" that program participants find coordination between FHA and HHS to be "generally seamless." However, that observation is missing from the "Results in Brief" section at the front of the report, which will be more widely read than the entire document.

A third example in which the report understates FHA's accomplishments is found in the "Results in Brief" section, which states: "Finally, FHA has not updated the program handbook, which contains program eligibility requirements, policies, and procedures, since 1984." This is true and is a valid criticism. While the eligibility requirements and policies in the handbook are generally still applicable, the procedures have changed considerably, and the handbook must be updated. However, the language in the draft report infers that HUD has not maintained current policies and procedures, which is not the case. The handbook is only one of a number of documents that provide program guidance. In fact, HUD has made continuous efforts to clarify program requirements and procedures, including updating the Applicant's Guide, developing the Application Process Checklist, and publishing a Mortgagee Letter. Establishment of a

preliminary review process and distribution of the "Minimum Criteria for Consideration" have clearly communicated HUD's eligibility requirements. Further, HUD has redesigned the program web page to include substantially more information for lenders and hospitals.

HUD suggests that GAO consider presenting a more balanced view of program and risk management in the "Results in Brief" section.

Comments on Risk Factors

In its discussion of potential risks, the draft report discusses a number of risk factors in the HUD insured portfolio and in the hospital industry in general. HUD is mindful of the factors that can cause hospital financial performance to decline, including factors discussed in the report. However, the Department offers the following comments on some of the factors that are cited as causes for concern:

- The draft report states: "For instance, the 43 New York hospitals currently insured through FHA rely heavily upon reimbursement through Medicare and Medicaid, making them vulnerable to state and federal cuts in these programs." While true, the statement implies that New York hospitals are especially vulnerable to Medicare and Medicaid cuts. In fact, nationwide in 2003, 52 percent of discharges were attributable to Medicare and Medicaid patients, slightly more than the 49 percent in New York. Potential cuts in reimbursement from these programs are a risk factor in all states.
- A second concern expressed in the draft report is that the commission appointed by the governor of New York to identify hospitals for closure or restructuring could recommend closure or restructuring of hospitals in the FHA portfolio, presenting the risk of an insurance claim. While this scenario is possible, HUD believes it is unlikely because the commission is required to consider the effect on lenders and bondholders in making its decisions. Although the commission is charged with making recommendations to restructure, the governor and legislature have committed \$1 billion of state funds over 4 years to assist restructuring efforts and improvements to healthcare information technology. These funds will assist the industry to restructure including consideration of debt. For a number of reasons, HUD believes that the State will avoid actions that would precipitate default on a HUD-insured mortgage that backs State-issued hospital bonds. In fact, New York State, through its Department of Health and the Dormitory Authority of the State of New York (DASNY), has a history of helping its hospitals avoid defaults¹. Furthermore, the FHA claim rate in the State, approximately one percent, is half of FHA's claim rate on hospital loans nationwide.
- HUD shares the concern in the draft report that a large insurance claim resulting from a default on a large New York mortgage (or for that matter, a large mortgage

¹ DASNY helps hospitals avoid defaults by providing low or no interest loans to improve efficiency and fund critical turnaround plans. DASNY also closely monitors and advises troubled hospitals and develops short- and long-term business plans. Most notably, along with HUD and the New York State Department of Health, DASNY helped Saint Vincent Catholic Medical Centers, Ellis Hospital, and Kingsbrook Jewish Medical Center avoid defaults.

in any state) poses a risk to the program. However, the report might note that the hospital given as an example (HUD's largest single exposure at \$828 million) is a financially sound, well-endowed institution that poses a low risk of default.

Comment on Processing Time

On the issue of processing times for applications, the interpretation of the data that GAO extracted from the program information system can be misleading. In the section on FHA's selection process, the draft report says that it took an average of 265 days to process the 11 applications for hospital mortgage insurance endorsed in fiscal year 2005. Unfortunately, HUD's tracking system does not currently capture "time outs" in the application review process that occur when the applicant must deal with issues that were not foreseen at the time the application was submitted, and which are beyond HUD's control. For example, the processing of the application for the University of New Mexico Hospital was delayed for several months after HUD received the application because the hospital encountered difficulty securing a lease on Native American land needed for the project. Furthermore, after beginning the review process of applications for Bucyrus Community Hospital and the Medical University Hospital Authority, the scope or cost of these projects were changed by the hospital, necessitating new feasibility studies. For these three projects, the delay ranged from approximately 90 days to 255 days.

Hospital projects are complex in nature, and there are many factors that can delay even a carefully planned project such as those mentioned above. HUD has strengthened its preliminary review procedures to require lenders and hospitals to develop solutions to identified problems before they submit an application. The preliminary review also increases program efficiency and reduces processing time because it eliminates from consideration, early in the process, those hospitals that do not qualify for the program. However, there will still be cases in which substantive issues arise during the underwriting process that may take some time to resolve. In the final report, HUD requests that GAO mention that processing times include suspensions of processing for matters beyond HUD's control.

Response to Conclusions

HUD takes strong exception to the sentence: "However, it is difficult for us, FHA's managers, or the Congress to assess how well the agencies perform in implementing the program because FHA has not established a set of meaningful performance measures or collected the information needed to assess performance." HUD believes that program results indicate that the program is fulfilling the public purpose for which it was designed and that it is doing so on a financially self-sustaining basis. Since program inception, 341 hospital loans have been insured for a total of \$11.9 billion, enabling hospitals in 41 states and Puerto Rico to obtain affordable financing for construction and modernization projects. By insuring projects that the private industry will not insure, Section 242 has enabled the provision of urgently needed health care services to the medically underserved, and spurred economic growth in those communities. Furthermore, the results have been accomplished at no net cost to the taxpayers; in fact, the hospital program has been a net contributor to the insurance fund. HUD requests that the "Conclusions" section be modified to present a more balanced picture that does not allow technical and procedural issues to overshadow real program accomplishments. More discussion on performance measures is found below.

Responses to Recommendations

Recommendation: Establish measurable and objective performance measures for the hospital program and collect appropriate information to regularly assess performance against the measures.

Response: HUD agrees on the importance of measurable and objective performance measures. At a high level, HUD has two performance measures for the program, both of which are measurable and objective:

1. Geographically diversify the portfolio by expanding program activity in all regions in order to reduce the risk associated with portfolio concentration in New York and to provide greater benefit to communities nationwide.
2. Maintain or reduce the program's historical claim rate of two percent of the amount of insurance written.

In addition, HUD has tracked two "customer service" performance measures, achievement of which can help bring about geographic diversification by making the program more attractive to lenders and hospitals:

3. Process 75 percent of complete applications within 120 days of receipt.
4. Process 75 percent of complete loan modification requests within 30 days of receipt.

HUD agrees that the measures for evaluating the performance of HHS under the interagency agreement are in some cases subjective and not easily measured, and that in other cases they could be measured, but are not. Although the performance measures in the interagency agreement were primarily meant to communicate HUD's expectations to HHS, HUD recognizes the value of performance measurement in both program administration and contract (interagency agreement) administration. The program office will work with HUD's Office of Policy Development and Research in order to develop the appropriate measures and implement data collection procedures to evaluate both program and contract administration.

Recommendation: Update the program handbook to make publicly available current eligibility requirements, policies, and procedures.

Response: While HUD does not agree that current eligibility requirements, policies, and procedures are unavailable to the public, it does recognize the need to consolidate those items in a new handbook. A new final rule governing the hospital program is being developed following the public comment period. That rule will provide the basis for the detailed guidance that will be promulgated in a new handbook. HUD's goal is to have the handbook in clearance by the end of calendar year 2006.

Recommendation: Develop a formal strategy to geographically diversify its portfolio of insured hospitals, including such elements as the processes, skills, technologies, and various resources that will be used to reach diversification goals.

Response: Although HUD has pursued a diversification strategy as discussed above, it agrees that a formal strategy would be useful and will formalize its strategy.

Recommendation: To potentially improve HUD's estimates of the program's annual credit subsidy rate, explore the value of explicitly factoring additional information, such as prepayment penalties and restrictions and the initial debt service coverage ratio of hospitals as they enter the program into the credit subsidy model.

Response: HUD welcomes GAO's suggestions that HUD revisit the calculation of the credit subsidy. In fact, the Department annually reviews the cash flow models that are used to estimate program performance and calculate subsidy rates. In addition, these models are reviewed by the independent auditor of the FHA financial statement and by OMB. Each year the models are updated for the latest loan performance statistics and suggestions for methodological improvements are considered. HUD will include GAO's suggestions in this ongoing process of attempting to utilize the most sound and accurate modeling techniques to estimate the cost of its mortgage insurance programs.

With respect to GAO's suggestion that the initial debt service coverage (DSC) ratio be incorporated as a factor in credit subsidy modeling, HUD would note that two of the studies cited in the footnotes in the report as technical support for this suggestion actually found this factor to be statistically insignificant in predicting commercial mortgage defaults. In any event, HUD does take into account the contemporaneous (not initial) DSC ratio in determining which currently insured hospital mortgages are financially troubled. This contemporaneous DSC ratio comes from the annual (audited) financial statements submitted by the hospital owners. It is not clear why HUD should consider using the initial DSC ratio in addition to the contemporaneous DSC ratio in making its artificial default adjustments for the hospital program.

Finally, HUD disagrees with the statement that "FHA estimates that hospital loans are most likely to experience a claim during their 10th insured year" and that since the majority of hospital loans are less than 10 years old, they are only now reaching a period when most claims occur. There appears to be a misunderstanding, because 70 percent of the claims and slightly more than 70 percent of the dollar amount of claims paid occurred prior to the 10th year. The relatively small population of loans and even smaller number of claims does not provide a statistically significant basis for predicting claims by loan age.

Conclusion

HUD has no fundamental disagreements with GAO's suggested improvements to the Section 242 hospital mortgage insurance program. HUD will pursue implementation of improvements along the lines suggested. HUD has a request to make of GAO with respect to the draft report, that positive program results be given the prominence they deserve. We suggest revising the "What GAO Found", "Results in Brief", and "Conclusions" sections of the final report to include this information, and changing the title of the report, "Program and Risk Management Could Be Enhanced", to reflect the accomplishments HUD has made since the last GAO report was completed in 1996.

Appendix IV
Comments from the Department of Housing
and Urban Development

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Technical comments and corrections to the draft report are enclosed. If you or your staff have any questions, please contact Michael Wells at 202-401-0450.

Sincerely,



Brian D. Montgomery
Assistant Secretary for Housing -
Federal Housing Commissioner

Enclosure

Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Resources and Services Administration

Rockville, Maryland 20857

FEB 9 2006

TO: David G. Wood
Director, Financial Markets and Community Investment
U.S. Government Accountability Office

FROM: Administrator

SUBJECT: Government Accountability Office Draft: "Hospital Mortgage Insurance Program and Risk Management Could be Enhanced"
(Code # GAO-06-316)

HRSA is pleased to comment on the GAO draft report under the terms of the Interagency Agreement between the Departments of Housing and Urban Development (HUD) and Health and Human Services (HHS) dated August 9, 2005. Under the agreement, "HUD is responsible for communication with other Federal agencies and members of Congress" on the hospital mortgage insurance program. Moreover, while HHS plays an important role in assisting HUD administer the program, HRSA wishes to speak in unison with HUD and incorporate HHS' comments with HUD, which is the agency statutorily responsible for the Program's management. Accordingly, we have shared our comments with HUD, reviewed HUD's response, and concur with HUD's observations and recommendations.

We wish to take this opportunity to express our appreciation on the positive findings of the draft report and are pleased that the GAO found that "FHA (Federal Housing Administration) and HHS appear to work together reasonably well in carrying out their respective roles in administering the program."

We appreciate the opportunity to have participated in this most important project to HUD and the GAO. Please contact William Tan at 301-443-5997 if you have any questions or require additional information.


Betty James Duke

GAO Contact and Staff Acknowledgments

GAO Contact

David G. Wood (202) 512-8678

**Staff
Acknowledgments**

Individuals making key contributions to this report included Alison Martin, Lisa Moore, David Pittman, Minette Richardson, Paul Schmidt, and Julie Trinder.

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