"FHA Hospital Mortgage Insurance: An Affordable Source of Construction Capital in a Turbulent Market."

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# FHA 242 Hospital Mortgage Insurance: An Affordable Source of Construction Capital in a Turbulent Market

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You're the CFO of a hospital requiring substantial renovation or a major expansion to remain competitive in today's health care market. Perhaps you need to replace a 40 year old rural facility to reverse out-migration and better meet the health care needs of your community. It should come as no surprise that today's erratic and unpredictable economy seriously challenges those objectives. In view of the recent downgrades of monoline insurers, construction cost inflation, uncertainty of future health care reimbursement, and the likelihood that rating agencies will tighten credit standards to the point that many previously investment grade hospitals will be significantly downgraded, an increasing number of hospitals are finding it difficult to access affordable construction financing.

These factors, together with the developments discussed below, have softened many hospitals' attitudes toward the Federal Housing Administration's (FHA) Section 242 Hospital Mortgage Insurance construction loan program (the 242 Program). Many sponsors are revisiting what was once considered an option of "last resort," concluding that the 242 Program is a viable, less expensive option for accessing affordable construction capital when compared with other financing options. While it is unlikely that top-tier facilities will view the 242 Program as an optimum financing source, the 242 Program has become increasingly appealing to hospitals whose access to affordable capital is expensive or threatened.

Aside from lower interest rate considerations, one reason for this newly found interest is fairly straightforward — FHA has made extensive efforts to address former industry concerns in a more "customer friendly" environment. The FHA's Office of Insured Health Care Facilities (OIHCF) in Washington, which administers the 242 Program, is demonstrating a more flexible, streamlined, and responsive approach to its program responsibilities. Program adjustments for these purposes have substantially decreased processing time for construction applications, closings, and post-completion asset management requests, factors which are at least partially responsible for significant increases in program volume. This article will discuss the 242 Program generally and several FHA innovations that have dramatically altered the perception of the program's viability as a source of affordable construction and permanent financing.

## *Overview of Section 242 Program*

Section 242 of the National Housing Act,[i] enacted in 1968, permits FHA to insure mortgage loans for the construction, rehabilitation, replacement, and equipping of hospital facilities, as well as refinancing of related existing debt.[ii] The program provides fixed interest rates, non-recourse terms, and a 25 year plus construction loan term[iii] without limits on mortgage size. "242 Loans" may be as high as 90 percent of the estimated project replacement costs, after giving credit for existing undepreciated plant, property, and equipment.[iv] The program is available for non-profit, public and private sponsors. In the case of non-profit or public entities, FHA permits any cash equity requirement to be satisfied by posting a letter of credit rather than cash at closing, allowing hospitals to continue fundraising efforts to meet the cash requirement once ground has broken.[v]

Participating hospitals have ranged from major national urban facilities to small rural and critical access hospitals. Since the late 1970s, program loans have largely been funded from the proceeds of tax-exempt revenue bonds (FHA Insured Mortgage Bonds), in turn collateralized by payments on and the FHA insurance of the 242 Loan. This collateral structure has permitted the FHA Insured Mortgage Bonds to be rated on the basis of the insurer's (FHA's) creditworthiness rather than that of the hospital. FHA Insured Mortgage Bonds receive investment grade ratings of at least AA. Since 1995, FHA Insured Mortgage Bonds have routinely been wrapped by monoline

insurers to gain AAA status. (In some instances, FHA Insured Mortgage Bonds have been rated AAA without any further credit enhancement.) Several hundred construction financings throughout the United States[vi] have been funded with FHA Insured Mortgage Bonds, although a 242 Loan may also be funded taxably through the sale of federally guaranteed Ginnie Mae Mortgage-Backed Securities. In the event of a 242 Loan default and a resulting insurance claim, FHA will pay benefits equal to 99 percent of the outstanding principal balance of the mortgage loan, plus accrued interest from the date of default.[vii]

Since program inception, more than 360 financings aggregating over $13.5 billion have been insured in 40 states.[viii] The 242 Program maintains one of the best claims records in the FHA portfolio,[ix] and because program mortgage insurance revenues have significantly exceeded total insurance claims over time, the 242 Program's federal credit scoring remains "negative." As such, the 242 Program does not require federal appropriations as a condition of FHA issuing an insurance commitment.

Unlike many conventional financing options, the 242 Program also provides a mechanism for hospitals to undertake major additions and improvements without having to refinance an existing 242 Loan, which at the time of a new financing may bear beneficial financing terms. FHA's Section 241 mortgage loan program,[x] a supplemental loan program, has been successfully used on a number of occasions for these purposes. At least forty-six "241 Loans" are currently outstanding. Moreover, the underwriting of a 241 Loan is generally less time consuming than the initial 242 Loan as a result of FHA's ongoing asset management role in the FHA financed projects. Additionally, Section 223(a)(7) of the National Housing Act,[xi] allows FHA to insure mortgage loans made to refund higher rate FHA indebtedness, i.e., 242 Loans and 241 Loans.

Key threshold requirements for 242 Program participation include:

- Hospital must demonstrate need (and obtain a CON if required in the state);[xii]
- Hospital must be able to provide first mortgage lien on the hospital's real estate;[xiii]
- At least 50 percent of total patient days are attributable to acute care services (critical access hospitals are exempt from this requirement);[xiv]
- Past three years average operating margin > 0;[xv]
- Past 3 years average debt service coverage ratio > 1.25;[xvi] and
- When justified by circumstances, financial margins above may be varied.

*Recent Improvements to Section 242 Program*

From the late-1970s through 2000, the 242 Program had been marked by an increasingly heavy Northeast concentration, particularly in New York where 89 percent of its portfolio was located at the highest point.[xvii] Several years ago, FHA's OIHCF recognized that if its hospital insurance program were to remain viable, portfolio diversification was essential. In order to achieve this objective, FHA undertook a substantive evaluation of its program processes, recognizing that guidelines must evolve to address both legitimate industry concerns and lingering misconceptions that caused many hospitals and financial advisors to reflexively avoid consideration of the 242 Program. Its efforts have yielded measurable results. Since 2000, FHA has issued 242 Loan insurance commitments (an FHA Commitment) in 16 other states and the New York concentration has been reduced to 52 percent, according to OIHCF. Based on the current pipeline, further diversification is anticipated.

*Staff and Mission Focus*

To assure it would be in a position to meet its legislative mandate to provide affordable health care capital, OIHCF has recruited a staff of highly-qualified and experienced individuals, who are by background broadly sensitized to hospitals' missions and the health care environment. OIHCF professional staff includes:[xviii]

- 11 former health care executives (including CEOs and CFOs)
- 3 former health care system executives
- 6 professional society fellows
- 24 have graduate degrees (includes 1 PhD, 3 juris doctors, and 9 MBAs)
- 4 CPAs
- 6 registered architects
- 3 professional engineers
- 1 registered nurse.

As important as staffs' experience is their attitude. The OIHCF staff is mission-driven and dedicated to making the 242 Program a successful and viable financing tool for hospitals ranging from large institutions to small rural facilities. Although FHA maintains serious and substantive underwriting standards, and although applicants will not always be satisfied with the process, the staff works to balance the responsibility of the federal government to protect a taxpayer backed insurance program with FHA's mission of facilitating affordable health care capital. While one may be reminded of the all too often used witticism, "I'm from the government and here to help you," in our perspective when this concept is applied to OIHCF, it may be considered a statement of mission, not a punch line.

Perhaps as importantly, a major 2007 program reorganization now permits the OIHCF staff to work in a more seamless manner to avoid what had been considered by many to be unnecessary management inefficiencies and borrower and lender frustration. Pre-2007, the 242 Program had been jointly administered by FHA and the United States Department of Health and Human Services. In 2007, however, the program was fully shifted to FHA and OIHCF staff appropriately increased to meet FHA's new workload considerations. This consolidation has permitted more efficient processing and timely responses both in terms of application underwriting and post-completion asset management needs.

As those participating in the health care sector surely know, hospitals occasionally hit rough spots. One advantage of participating in the 242 Program is that portfolio hospitals will have found a partner to work with them through trying times, as well as during the project development stage. In one recent case, a small Section 242 rural facility in a distressed situation found that it had neither staff nor resources to effectively address a recovery solution. Within a week of being approached by the facility, OIHCF retained and paid for a consultant to work with the facility on a turnaround. It also approved a supplemental loan in a matter of weeks to assist the new business plan, reactions not readily available in the earlier years of the program.

OIHCF also meets regularly with private sector health care interests, including the Committee on Healthcare Financing, a coalition of mortgage and investment banks, consultants, and bond insurers that have been active in the program since the early 1980s, to consider new means for addressing industry concerns and improving the program process. OIHCF has also worked collaboratively with the private sector to implement many of the statutory and administrative changes discussed in this article and has recently held two lender training sessions to better educate that community on program processes and benefits.

*Application Processing Improvements*

The often extended timeframe between a hospital's insurance application and the issuance of an FHA Commitment has been a common criticism over the years. While there will undoubtedly be cases that experience protracted underwriting periods, OIHCF has in recent years implemented several strategies to significantly reduce processing time, essentially by eliminating redundant and unnecessary underwriting criteria without compromising legitimate 242 Program standards. An example of one recent initiative is that FHA now assigns the Account Executive responsible for initial application underwriting to serve as point person for that facility after a project's completion to assure the continuity necessary to allow hospital operating concerns to be readily

identified and addressed. Although FHA processing may still take longer than conventional financings, FHA's website indicates that median processing times have improved from 224 days in FY 2005 to 115 days in FY 2006 to 51 days in FY 2007.[xix]

What may be more significant to the program's long range success is the recent implementation of the "LEAN OFFICE" management efficiency tool,[xx] designed to improve productivity by identifying and eliminating inefficient and redundant office practices without comprise to product quality. This past April, OIHCF coordinated a three day working session that included a major private sector LEAN strategist, FHA lenders, Committee on Healthcare Financing representatives, and 242 Program hospital executives (from a major tertiary facility and a critical access hospital) to evaluate the LEAN tool utility for further streamlining the application and underwriting process. Although not fully implemented, several session recommendations are now in place. OIHCF eventually expects to expand the LEAN process to its asset management function as well.

OIHCF has also worked closely with industry groups, such as the Committee on Healthcare Financing, to eliminate some of the more cumbersome aspects of the 242 Loan closing process, the benefits of which are already being realized. Similar streamlining efforts have been initiated for post-completion asset management needs, resulting in more timely responses to requests, such as requests to release vacant portions of a mortgage site for the development of new health care facilities. A response can now be expected in as few as 30 days.

Finally, OIHCF has also made inroads in the use of Internet technology for outreach to the public, and this past year launched a revamped 242 Program website.[xxi] The revised site includes the 242 Program application and eligibility information, as well as other matters of interest.[xxii] Finally, FHA is well down the road in developing a WEB portal that will allow the application and other 242 Program processes to be submitted electronically. The new portal should be available by early 2009.

*Asset Management and Flexibility*

FHA has repeatedly demonstrated a commitment to work closely with stressed portfolio hospitals and relevant local state agencies and courts to develop workout strategies and recovery plans to permit affected hospitals to react to today's turbulent economic environment. In this capacity, certainly FHA is mindful of its interests as the insurer of the 242 Loan, but this consideration appears to be tempered by its legislative mission of assuring quality patient care in underserved communities. On more than one occasion, OIHCF has retained private workout specialists to assist distressed facilities and has permitted hospitals to use their FHA-required reserves for debt service and capital and operational improvements to implement new business strategies.

Over the years, one impediment to achieving optimum interest rates on FHA Insured Mortgage Bonds and therefore the 242 Loan has been FHA's regulatory option to pay an insurance claim in cash, FHA debentures, or a combination of both, which FHA determines at the time of insurance claim payment.[xxiii] The issue affected both the initial financing and the potential for advance and current refundings in improved interest rate markets. It arose from the uncertainty as to which option FHA would exercise in the event of a 242 Loan default. In order to meet governing rating agency criteria, that in turn required an increased average life of the related FHA Insured Mortgage Bonds and higher financing interest rates. To achieve more optimum pricing (and therefore lower 242 Loan interest rates), FHA worked with lenders to develop protocols where, if significant savings could be demonstrated, FHA would agree, at the time of the 242 Loan's closing or refunding, to pay an insurance claim, if made, in either cash only or debentures only, depending on the underlying financial structure. Protocols used for these purposes are popularly referred as FHA's "debenture lock" and "cash lock" programs, and their flexible implementation not only results in lower interest rates but also reduced bond negative arbitrage requirements for invested construction funds.

*Large Urban Facilities and Hospital Systems*

While FHA has increased its efforts to reach out to a more diversified group of hospitals, especially small rural and critical access hospitals, it continues to implement more flexible guidelines for working with larger urban and suburban institutions. Recognizing that many of these large participants often maintain higher financial margins than its wider portfolio, FHA recently created a new category of applicants, known as "Tier One" credits, entitling those facilities to achieve more flexible operating covenants in the underlying 242 Loan documents. Under this approach, eligible institutions will be entitled to covenant requirements, for example, which allow a hospital to distribute assets (including cash) to affiliates or obtain additional debt, including capital leases, without obtaining prior FHA approval in those circumstances where that approval is required. Hospitals, regardless of size, are eligible for Tier One status, although to date the program has been applied primarily to larger urban facilities. While now achieved on a case by case basis, FHA is considering the permanent implementation of this strategy.

*System Participation*

While national and regional hospital systems were at best minimally interested in the 242 Program, that no longer appears the case and recently, several regional systems have closely examined the utility of the program as a financing tool. In view of this newly emerging interest, OIHCF recently hired a retired former executive of a major mid-west health care system to head its efforts to develop guidelines that would permit systems to more comfortably utilize the 242 Program. Given the flexibility OIHCF has demonstrated in connection in other matters, one may reasonably conclude that appropriate program adjustments will be made to permit more viable system participation.

*Rural Facilities and Critical Access Hospitals*

There are nearly 1800 small rural hospitals across the county, of which approximately 1300 have received Critical Access Hospital designation.[xxiv] Many were built more than 40 years ago with Hill-Burton funds and are in need of significant renovation or outright replacement. Unfortunately, until 2003, the 242 Program was unavailable for many of these facilities because Section 242 prohibits more than 50 percent of a facility's patient days from being attributable to skilled nursing care. Because a substantial number of CAH facilities had nursing home components in excess of this limitation, FHA has supported two amendments to Section 242 (one in 2003 and another in 2006) to exempt CAH from this patient day test. [xxv]

Other program enhancements have also been implemented to assure CAH access to the 242 Program. Recognizing the need of rural communities and that CAH facilities in particular often lack the resources to retain professionals to assist with the complex nature of modernization and replacement projects, OIHCF as a part of its new partnership orientation has developed an accelerated application process and separate application guide for CAH facilities. In certain circumstances, FHA has used its own resources to assist in connection with CAH project developments.

Another major program innovation, announced at a recent Committee on Healthcare Financing meeting, is FHA's willingness to approve the "design build" construction concept for projects of $30 million or less of construction costs.[xxvi] Under this strategy, architectural and construction functions may be handled by a single firm. The strategy is viewed both as an opportunity to decrease project construction costs, but also as a means of financing (through the design-builder) the substantial front end costs of project development. Although design-build would be available for any hospital, because of its current cost limitation, it is expected to be used primarily by CAHs and other rural facilities.

*242 Loan Covenants – New Flexibility in Practice*

Not unlike its conventional brethren, the 242 Program requires participants to agree to a series of financial and management covenants governing mergers, financial reporting, additional indebtedness, changes in reimbursement, and equipment leasing, among other issues. In line with their customer-oriented focus, FHA will consider modifications to its standard version of covenants to reflect specific operating characteristics and needs of an applicant and to meet state law requirements. Some would argue that FHA's covenants are more onerous than conventional financings, though in today's marketplace that view is certainly debatable. In fact, many covenant violations will not cause the hospital to be considered "in default," but would obligate the hospital to obtain FHA prior approvals before undertaking certain actions. (For example, falling below 21 days cash on hand does not put a hospital in default, but merely restricts its ability to enter into capital leases without FHA consent.)

But even if FHA-required covenants impose more oversight than conventional financings, in an uncertain and constantly evolving health care sector, the 242 Program offers more back end flexibility in the event of financial crisis or legitimate project needs. In conventional bond financings bond trustees are generally unwilling or unable to address the changing realities of the evolving health care market. Therefore, the opportunity to modify governing bond covenants in conventional cases is severely limited. On the other hand, FHA is not so restrained and has broad authority and has demonstrated a willingness to exercise that authority to modify its covenants when in the interests of its customer hospital. Moreover, bond documents used in FHA Insured Mortgage Bond financings generally defer to FHA as to the nature and enforcement of the relevant covenants.

*Statutory Changes to Expand Program Availability*

As enacted in 1968, Section 242 of the National Housing Act originally required a hospital to obtain a state Certificate of Need (CON) in order to be program eligible. For many years, this requirement was of little concern as all but two states maintained active CON programs. However, by the early 1980s an increasing number of states had terminated their CON programs, and the CON requirement soon became a "drop-dead" impediment to eligibility. With cooperation from FHA, Capitol Hill, and the private sector, Section 242 has been amended to enable hospitals in non-CON states to retain a feasibility consultant to prepare a market need study to substitute for the former CON requirement.[xxvii] As a result, the 242 Program is now available in states where it had been temporarily unavailable, including California, Texas, and Florida, among others.[xxviii]

*Conclusion*

By the end of third quarter FY 2008, FHA entertained nearly twice the number of inquiries, preliminary reviews, and applications than in any prior year. In view of existing market conditions, FHA expects that this escalating program interest will continue. OIHCF is not only patently aware of this trend, but recognizes it needs to continuously improve and rethink existing program guidelines to assure Congressional objectives can be met. FHA's OIHCF appears to view its role in the new market environment as an opportunity, if not an obligation, not only to fulfill its Congressionally mandated mission of assuring access to health care in undercapitalized communities, but to diversify and upgrade its portfolio, as well. While many hospitals, bankers, and financial advisors will undoubtedly continue to view the 242 Program as a "last resort" option, upon closer examination, it may be more reasonable for them to conclude that OIHCF has demonstrated a clear willingness to assure that the 242 Program remains a strong and viable financing option, and that OIHCF will approach its responsibilities with the same sense of mission and flexibility demonstrated in recent years. With the credit crisis making it more difficult for investment and non-investment grade health care credits to access affordable capital, the 242 Program should be considered a viable alternative for affordable health care financing.

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[i] 12 U.S.C. § 1715z-7 (2008).

[ii] At a minimum, "the hard costs of construction and equipment must represent at least 20 percent of the total mortgage amount." *See* 24 C.F.R. § 242.15 (2008).

[iii] 24 C.F.R. § 242.27.

[iv] 12 U.S.C. § 1715z-7(d)(2).

[v] 12 U.S.C. § 1715z-7(d)(6).

[vi] Since its inception, FHA has insured hospital projects in all states except Alaska, Delaware, Georgia, Hawaii, Iowa, North Dakota, Vermont, Wyoming, and the District of Columbia according to OIHCF.

[vii] 12 U.S.C. § 1713(g) (2008).

[viii] Federal Housing Administration, http://portal.hud.gov/portal/page?_pageid=73,1826910&_dad=portal&_schema=PORTAL (last visited July 18, 2008).

[ix] According to OIHCF, the 242 Program has paid out 24 insurance claims in the past 40 years and has recovered 68 percent of amounts paid.

[x] 12 U.S.C. § 1715z-6.

[xi] 12 U.S.C. § 1715n(a)(7).

[xii] 12 U.S.C. § 1715z-7(d)(4)(B).

[xiii] In several cases where a publicly owned hospital was restricted from granting mortgages, FHA worked with the hospitals and local governing entities to develop ownership arrangements meeting both state and federal requirements and allowing the hospitals continued operations in conformity with community needs.

[xiv] 12 U.S.C. § 1715z-7(b)(1)(B).

[xv] 24 C.F.R.§ 242.16(a)(2)(i).

[xvi] 24 C.F.R.§ 242.16(a)(2)(ii). For recently designated critical access hospitals, FHA allows a hospital to recast its financial ratios as if it had been a CAH for the past three years**.** *See Guidelines for Preparation of Feasibility Studies and Determination of Need HUD Section 242 Program, Critical Access Hospitals*, available from OIHCF.

[xvii] United States Government Accountability Office Report to Congressional Committees, *Hospital Mortgage Insurance Program – Program and Risk Management Could Be Enhanced*, GAO-06-316 (Feb. 2006), at 23.

[xviii] Power Point Presentation by HUD, *HUD's Vision for the Future – 232/223(f) LEAN Processing Training For Lenders, June 30-July 1, 2008*, http://portal.hud.gov/portal/page?_pageid=73,3915250&_dad=portal&_schema=PORTAL (follow "Power Point slides from the June 30-July 1 HUD Underwriter Training" hyperlink) (last visited July 18, 2008).

[xix] Federal Housing Administration, *Health Care Facilities Mortgage Insurance for Hospitals Median Processing Time Drops to 51 Days in FY 2007*, http://portal.hud.gov/portal/page?_pageid=73,1826982&_dad=portal &_schema=PORTAL(last visited July 18, 2008).

[xx]A processing methodology derived in the 1970's from Toyota's Production System.
[xxi]OIHCF website is www.fha.gov/healthcare.
[xxii]*See* http://portal.hud.gov/portal/page?_pageid=73,1826910&_dad=portal&_schema=PORTAL.
[xxiii]24 C.F.R. § 207.259(a) (2008).
[xxiv]Flex Monitoring Team, *A Complete List of Critical Access Hospitals (1,289 Critical Access Hospitals)* (current as of April 1, 2008), http://www.flexmonitoring.org/documents/CAHList_04_01_08.xls (last visited July 18, 2008).
[xxv]12 U.S.C. § 1715z-7(b)(1)(B) and 1715z-7(i)(1).
[xxvi]OIHCF Address at the Committee on Healthcare Financing Annual Meeting, in Washington, D.C. (June 12, 2008).
[xxvii]12 U.S.C. § 1715z-7(d)(4)(B).
[xxviii]Last September, FHA issued a FHA Commitment for approximately $70 million for a major hospital rehabilitation project in California; the project closed within 2 months.