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Report to Congressional Requesters

January 2024

HOSPITAL FINANCING

Volume Limits and Reporting Could Help Manage Risks of Expanding FHA's Mortgage Insurance Program

Accessible Version

GAO-24-106480

GAO Highlights

Highlights of GAO-24-106480, a report to congressional requesters

January 2024

HOSPITAL FINANCING

Volume Limits and Reporting Could Help Manage Risks of Expanding FHA's Mortgage Insurance Program

Why GAO Did This Study

FHA's Hospital Mortgage Insurance Program currently insures more than $6 billion in loans for the expansion and renovation of hospitals that provide general acute care services, such as surgeries and treatments for injuries and short-term illnesses. Legislation introduced but not enacted in the 117th Congress proposed extending eligibility to hospitals that primarily provide non-acute care services, such as treatment of mental health disorders.

GAO was asked to evaluate the potential effects of expanding program eligibility. This report examines (1) use of the program from fiscal years 2000–2022, (2) characteristics of ineligible hospital types that may affect their financing options, and (3) the potential effects of extending eligibility on program participation and risks.

GAO analyzed FHA documents and data for fiscal years 2000–2022; hospital financial data from the Centers for Medicare & Medicaid Services for 2016–2020 (the most recent available year); and industry, academic, and government reports. GAO also interviewed representatives from FHA, lenders, mental health providers, appraisers, and hospital and health care associations.

What GAO Recommends

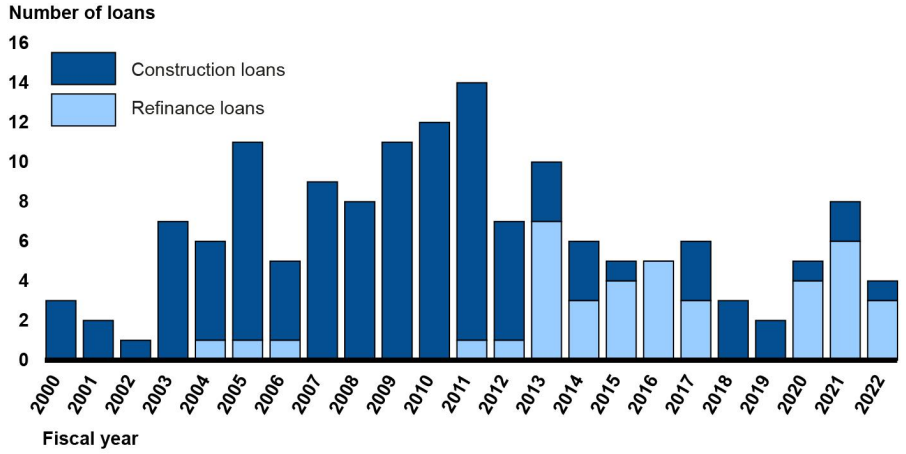
If Congress decides to expand program eligibility, it should consider adopting practices to help manage potential risks. These could include initially limiting the volume of loans to new hospital types and requiring FHA to regularly report on new program activity. FHA did not have any comments on the report.

View GAO-24-106480. For more information, contact Jill Naamane at (202) 512-8678 or naamanej@gao.gov.

What GAO Found

The Federal Housing Administration's (FHA) Hospital Mortgage Insurance Program insures loans for capital improvements at hospitals that primarily provide general acute care services. The number and types of loans FHA insured annually varied in fiscal years 2000–2022, partly in response to economic conditions and program expansions. For example, program use temporarily increased in 2009 following creation of the Build America Bonds program (which incentivized infrastructure projects) and in 2013 following a program expansion that codified certain options to refinance non-FHA-insured debt.

Number of New Hospital Mortgage Loans Insured Annually by FHA, by Loan Type, Fiscal Years 2000–2022



Source: GAO analysis of Federal Housing Administration (FHA) data. | GAO-24-106480

Accessible data for Number of New Hospital Mortgage Loans Insured Annually by FHA, by Loan Type, Fiscal Years 2000–2022

Year	Refinanced Loans	Construction Loans
2000	0	3
2001	0	2
2002	0	1
2003	0	7
2004	1	5
2005	1	10
2006	1	4
2007	0	9
2008	0	8
2009	0	11
2010	0	12
2011	1	13

Year	Refinanced Loans	Construction Loans
2012	1	6
2013	7	3
2014	3	3
2015	4	1
2016	5	0
2017	3	3
2018	0	3
2019	0	2
2020	4	1
2021	6	2
2022	3	1

Source: GAO analysis of Federal Housing Administration (FHA) data. | GAO-24-106480

Hospital types generally ineligible for FHA's program, such as psychiatric and long-term care hospitals, have characteristics that can limit their financing options or increase financing costs compared to eligible hospital types. They are generally smaller facilities and have lower average revenues and profit margins than eligible hospital types. Hospitals with smaller revenue bases and weaker financial performance may have difficulty qualifying for affordable loans or securing public credit ratings needed to issue bonds.

Extending the program to ineligible hospitals could increase program participation and risks, but specific effects are difficult to estimate. GAO estimates that about 2,600 additional hospitals could become eligible, but the number that could meet FHA's underwriting standards is unknown, and some characteristics of these hospitals could add uncertainty to FHA's underwriting process. For example, less predictable revenue sources at some psychiatric hospitals could challenge FHA's ability to estimate long-term default risks. Prior practices Congress has used to manage FHA program risks may be applicable to expanding the hospital program. These include initially limiting the volume of new loans and requiring FHA to regularly report on program activity, including the performance of new loans. Such practices would help ensure that program risks related to an expansion were effectively monitored, controlled, and evaluated.

Contents

Abbreviations

CMS	Centers for Medicare & Medicaid Services
FHA	Federal Housing Administration
USDA	Department of Agriculture

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January 25, 2024

The Honorable Patrick McHenry
Chairman
Committee on Financial Services
House of Representatives
The Honorable Warren Davidson
Chairman
Subcommittee on Housing and Insurance
Committee on Financial Services
House of Representatives
The Honorable Tom Emmer
House of Representatives
The Honorable Ritchie Torres
House of Representatives

The Federal Housing Administration's (FHA) Hospital Mortgage Insurance Program insures mortgage loans to finance the renovation or construction of hospitals that might otherwise have difficulty accessing capital.[1] The insurance protects lenders against losses they might incur if hospitals fail to make their loan payments. Since its inception in 1968, the program has insured more than $22 billion in loans for hospitals in 43 U.S. states and Puerto Rico.

FHA's general authority to insure hospital loans is contained in Section 242 of the National Housing Act.[2] Section 242 limits insurance eligibility to inpatient hospitals that use at least one-half of their patient days to provide general acute care services, such as surgeries and treatments for injuries and short-term illnesses.[3] Other sections of the act authorize FHA

[1]FHA is a component of the Department of Housing and Urban Development.

[2]12 U.S.C. § 1715z-7.

[3]Specifically, eligibility is limited to hospitals that provide not more than 50 percent of their total patient days during any year to care that is customarily assignable to the following categories: chronic convalescent and rest, drug and alcoholic, epileptic, mentally deficient, mental, nervous and mental, and tuberculosis. 12 U.S.C. § 1715z-7 (b)(1)(B).

to insure loans that supplement or refinance Section 242 loans, and to insure loans that refinance hospital debt not insured by FHA.[4]

Because of the Section 242 patient-day requirement, current program participants are largely general acute care hospitals. We refer to these kinds of hospitals as eligible hospital types because they generally meet the program's statutory definition of an eligible hospital, including the patient-day requirement.[5] Other kinds of hospitals, such as those that focus on mental health or physical rehabilitation, are generally not eligible for the program because they do not meet the patient-day requirement. We refer to these as ineligible hospital types, recognizing that actual eligibility determinations are made on a hospital-specific basis.

Legislation was introduced, but not enacted, in the 117th Congress (2021–2022) to provide parity in accessing the Hospital Mortgage Insurance Program. Specifically, the proposed *Securing Facilities for Mental Health Services Act* sought to expand program eligibility to a wider variety of hospitals by eliminating the program's patient-day requirement.[6]

You asked us to evaluate the potential effects of eliminating the program's acute-care patient-day requirement, thus extending eligibility to ineligible hospital types. This report examines the (1) usage of the Hospital Mortgage Insurance Program from fiscal years 2000 through 2022 and the factors that contributed to changes in size and participation, (2) characteristics of ineligible hospital types and their potential effect on these hospitals' financing options, and (3) potential effects of extending eligibility to currently ineligible hospital types on program participation and risks.

For the first objective, we analyzed FHA data on loans insured through the program from fiscal years 2000 through 2022. Among other things, we calculated the annual number and dollar amount of new loans insured, examined trends in the program's total insurance outstanding at the end

[4]12 U.S.C. § 1715z–6, 12 U.S.C. § 1715n(f), and 12 U.S.C. § 1715(a)(7). Hospitals applying for loans that supplement or refinance Section 242 loans do not need to meet the patient-day requirement. Hospitals applying for loans that refinance hospital debt not insured by FHA must meet the patient-day requirement.

[5]Besides meeting the patient-day requirement, a hospital must provide inpatient medical care of the sick or injured and be licensed and regulated by a state or a political subdivision thereof to meet the statutory definition. 12 U.S.C. § 1715z-7(b)(1)(A) and (C).

[6]Securing Facilities for Mental Health Services Act, H.R. 8179, 117th Cong. §2 (2022).

of each fiscal year, and analyzed the geographic distribution of hospitals in FHA's loan portfolio.[7]

For the second objective, we reviewed prior reports and research on the financing of ineligible hospital types and characteristics of those hospitals that could affect their ability to obtain financing. We analyzed data from the Centers for Medicare & Medicaid Services' (CMS) Healthcare Cost Report Information System (Cost Report data) for fiscal year 2016 through fiscal year 2020 (the most recent complete year available at the time of our analysis).[8] We compared the size, revenue, profitability, and ownership of eligible and ineligible hospital types.

For the third objective, we reviewed FHA underwriting standards and other documentation on the agency's loan application review process. We also analyzed CMS Cost Report data for fiscal year 2020 to estimate the number of hospitals currently eligible for FHA's program and the number of additional hospitals that could become eligible if the patient-day requirement were removed. Additionally, we reviewed prior reports and research on the characteristics of ineligible hospital types and previous GAO reports on managing FHA's mortgage insurance risks. Further, we reviewed FHA information related to potential financial and operational risks to the program if it were expanded, including budget and staffing data.

For all objectives, we interviewed officials from FHA's Office of Health Care Programs and Office of Risk Management and Regulatory Affairs. We also interviewed representatives from national hospital groups and industry groups representing ineligible hospital types; administrators of ineligible hospital types; and FHA program participants such as lenders, appraisers, and financing consultants. Additionally, we interviewed officials from the Department of Agriculture (USDA), which operates grant, loan, and loan guarantee programs that serve rural health care facilities. We also interviewed representatives from the three largest credit rating agencies, which rate bonds used to finance hospitals, including some with FHA-insured mortgages. We selected these entities to represent a range of stakeholders involved in or potentially affected by

[7]To assess the reliability of the FHA data, we conducted electronic testing and interviewed knowledgeable agency officials. We determined these data were sufficiently reliable for purposes of characterizing the volume and geographic distribution of FHA's insurance activity.

[8]To assess the reliability of the CMS data, we reviewed CMS documentation and interviewed knowledgeable agency officials. We determined these data were sufficiently reliable for purposes of classifying hospitals based on facility type and describing basic characteristics and selected financial metrics of those hospitals.

changes to FHA's program. Appendix I describes our scope and methodology in greater detail.

We conducted this performance audit from December 2022 to January 2024 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Hospital Mortgage Insurance Program

In 1968, 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.[9] Through this program, FHA insures the mortgage loans lenders make for the construction and renovation of hospitals. Without FHA insurance, the hospitals that participate in the program might otherwise be unable to get affordable loans for capital improvements because they typically are higher credit risks than other general acute care hospitals.

The program generally provides mortgage insurance for general acute care hospitals and hospitals in health systems.[10] Eligible hospitals can use the loans for a range of capital improvement projects, including facility replacement, remodeling, expansion (including the acquisition of existing facilities), modernization, and equipment purchases. In exchange for upfront fees and annual insurance premiums, participating hospitals

[9]Pub. L. No. 90-448, § 1501, 82 Stat. 476, 599 (1968). The Hospital Mortgage Insurance Program supplemented the Hill-Burton Program. Under Hill-Burton, the Department of Health and Human Services (formerly the Department of Health, Education, and Welfare) made loan guarantees and direct loans to hospitals for construction and modernization projects.

[10]Acute care hospitals provide inpatient medical care and other related services for surgery, acute medical conditions or injuries, usually for a short-term illness or condition.

can get a 25-year loan (with a loan-to-value ratio of no greater than 90 percent of replacement cost) that is 99 percent insured by FHA.[11]

FHA's Office of Hospital Facilities administers the Hospital Mortgage Insurance Program and consists of two divisions. The underwriting division reviews and processes loan applications using FHA's underwriting standards. The asset management division monitors the financial status of loans and hospitals in FHA's portfolio and takes default prevention actions, as necessary.

The Hospital Mortgage Insurance Program is one of many credit programs under FHA's General Insurance and Special Risk Insurance Fund.[12] By dollar volume, the program accounted for about 4 percent of the outstanding principal of the loans insured under the fund, as of the end of fiscal year 2022. Through the appropriations process, Congress sets limits on the total dollar amount of loans FHA can insure under the fund account but does not set program-specific limits.

Like other federal credit agencies, FHA is required to estimate the net long-term cost to the government—or credit subsidy cost—of the loans it insures each year.[13] If the present value of estimated cash outflows exceeds the present value of cash inflows, there is a positive subsidy cost. If the present value of estimated cash inflows exceeds the present value of cash outflows, there is a negative subsidy cost, referred to as subsidy income. Subsidy cost estimates are generally updated—or reestimated—annually after the end of the fiscal year to reflect actual loan performance and to incorporate any changes in assumptions about future loan performance.

[11]FHA charges hospitals application and commitment fees that aggregate to $3 per $1,000 of the amount of the loan. The annual premium ranges from 55 to 70 basis points, depending on the type of loan. The loan-to-value ratio is the amount of the loan divided by the replacement cost of the hospital at the time of loan origination.

[12]The programs in the fund address specialized financing needs, including insurance for loans to develop, rehabilitate, and refinance multifamily rental housing, nursing home facilities, and hospitals.

[13]To calculate these subsidy costs, agencies must calculate, by annual loan cohort, the net present value of the estimated cash outflows from the government (e.g., payments to lenders to honor guarantees on defaulted loans) minus estimated cash inflows to the government (e.g., fees paid by borrowers and lenders), over the life of the loan and excluding administrative costs.

The Hospital Mortgage Insurance Program consists of four subprograms that correspond to different sections of the National Housing Act, as follows:

- **Section 242.** Loans for hospitals without existing FHA-insured loans that are seeking financing for construction projects. Hospitals may use loan proceeds to refinance existing debt, but at least 20 percent of the loan must be used for construction and equipment costs.
- **Section 241.** Supplemental loans for hospitals with existing FHA-insured loans that are seeking financing for capital improvements, expansions, or rehabilitation.
- **Section 223(a)(7).** Refinancing of existing FHA-insured loans. In very limited circumstances, loan proceeds may also be used to fund critical repairs on the mortgaged property.
- **Section 223(f).** Refinancing of existing debt not insured by FHA. Hospitals may use less than 20 percent the loan proceeds to fund rehabilitation, but at least 80 percent of the loan must be used to refinance debt. Loan proceeds may also be used to acquire an existing hospital.

Hospitals must meet the program's statutory definition of a hospital to be eligible. They must

- provide inpatient medical care of the sick or injured;
- have at least 50 percent of adjusted patient days in acute care categories;[14] and
- be licensed and regulated by the state or a political subdivision of the state.

Hospitals meeting this definition must also satisfy multiple FHA underwriting requirements to qualify for insured loans. For example, FHA regulations require hospitals to

- demonstrate a market need for the hospital;[15]

[14]Because hospitals have increasingly shifted care to outpatient settings, FHA uses an adjusted patient-day calculation that accounts for the acute care provided on an outpatient basis. As previously noted, hospitals applying for loans that supplement or refinance Section 242 loans do not need to meet the patient-day requirement.

[15]FHA evaluates market need for the hospital through an analysis of the hospital's service area definition, its historical utilization, occupancy rate, forecasted population growth, competitor data, and other factors. 24 C.F.R. § 242.16.

- generally have a 3-year aggregate operating margin of 0 percent, or better;[16] and
- generally have a 3-year average historical debt-service coverage ratio of 1.25 or better.[17]

Some requirements differ for refinance loans. For example, a hospital applying to refinance existing debt not insured by FHA must have a 3-year average historical debt-service coverage ratio of 1.4 or better. Among other things, the hospital also must demonstrate that its financial performance would be materially improved by refinancing its existing capital debt.

Section 242 of the National Housing Act restricted participation to hospitals that primarily provide general acute care, thereby excluding other types of hospitals, such those focusing on behavioral health. This restriction is generally consistent with the exclusion of "institutions for mental diseases" that was part of the creation of Medicaid in 1965.[18] The exclusion prohibits federal payments to states for services provided to most adult Medicaid beneficiaries who are residents of these institutions, whether services are provided inside or outside of them. Congress limited its support for these institutions because state and local governments had historically financed inpatient care for people with psychiatric conditions, and because of deinstitutionalization. Deinstitutionalization refers to the transition of care for people with behavioral health conditions—mental health and substance use disorders—from institutions to community settings.

If a hospital believes it is eligible and chooses to apply for FHA's program, it works with a lender to complete the application process. FHA reviews

[16]A hospital's operating margin is calculated by subtracting the hospital's total operating expenses from its total operating revenue and dividing that result by the hospital's total operating revenue. 24 C.F.R. § 242.1. For start-up facilities that do not have an operating history, other factors become more important in FHA's review of the potential borrower.

[17]Debt-service coverage ratio is a measure of a hospital's ability to pay interest and principal on debt with cash generated from current operations. It is calculated by adding the hospital's excess revenues over expenses (or net income for for-profit organizations), interest expense, depreciation expense, and amortization expense, and dividing that result by the sum of the current portion of long-term debt from the prior year and the interest expense. 24 C.F.R. § 242.1.

[18]Institutions for mental diseases are defined as hospitals, nursing facilities, and other institutions that have more than 16 beds and are primarily engaged in diagnosing, treating, or caring for people with mental diseases, including medical attention, nursing care, and related services. 42 U.S.C. § 1396d(i). The exclusion currently applies only to Medicaid beneficiaries aged 21–64.

the application and performs an underwriting analysis. If FHA approves the application, it issues a commitment to provide the mortgage insurance. According to FHA officials, FHA's goal is to finish its review of a complete application within 120 days.[19] Following issuance of the commitment, the lender closes on the mortgage loan.

Types of Hospitals

According to fiscal year 2020 CMS data—the most recent complete data available at the time of our analysis—there were about 6,000 hospitals operating in the United States and its territories. CMS classifies hospitals into several types (see table 1). Although eligibility for FHA's program is based on a case-by-case evaluation against specific requirements, hospital type is a general indicator of program eligibility, as shown in the table.

Table 1: Types of Hospitals Generally Eligible and Ineligible for the Hospital Mortgage Insurance Program (Fiscal Year 2020 Data)

	Type of hospital	Description	Number of active hospitals
Eligible for program	Children's hospital	A hospital with inpatients predominantly aged 18 or younger.	92
	Short-term	A hospital that provides acute inpatient care.	3,213
	Subtotal	NA	**3,305**
Ineligible for program	Critical access	A small facility that gives limited outpatient and inpatient hospital services to people in rural areas.	1,344
	Long-term	A hospital with an average inpatient length of stay of greater than 25 days.	345
	Psychiatric	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.	458
	State psychiatric	State-administered facilities that include hospitals for children, adults, older persons, and people who have entered the mental health system via the court system.	156
	Rehabilitation	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.	314
	Subtotal	NA	**2,617**

[19]The target time varies by the type of loan, ranging from 60 days for a Section 223(a)(7) refinance application to 120 days for a Section 241 or 242 application. According to FHA officials, the goals apply to the time FHA actively works on the application and exclude the time FHA waits for additional information from the applicant.

	Type of hospital	Description	Number of active hospitals
Eligible and Ineligible	**Total**	NA	**5,922**

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-24-106480

Note: We define eligible hospital types as those that generally meet the Federal Housing Administration's (FHA) Hospital Mortgage Insurance Program's patient-day requirement because they primarily provide general acute care services. We define ineligible hospital types as those that generally do not meet the patient-day requirement because of the kinds or mix of services they provide. Although some critical access hospitals may meet the patient-day requirement, we classify critical access hospitals as generally ineligible because congressional waivers that previously allowed broad participation of critical access hospitals have expired. Our eligibility analysis excludes hospitals that are likely to be ineligible for FHA's program for reasons other than the patient-day requirement or for which the facility type was unclear.

Economic and Program Changes Contributed to Fluctuations in Program Volume and Participation

Program Volume Varied Amid Economic and Program Changes

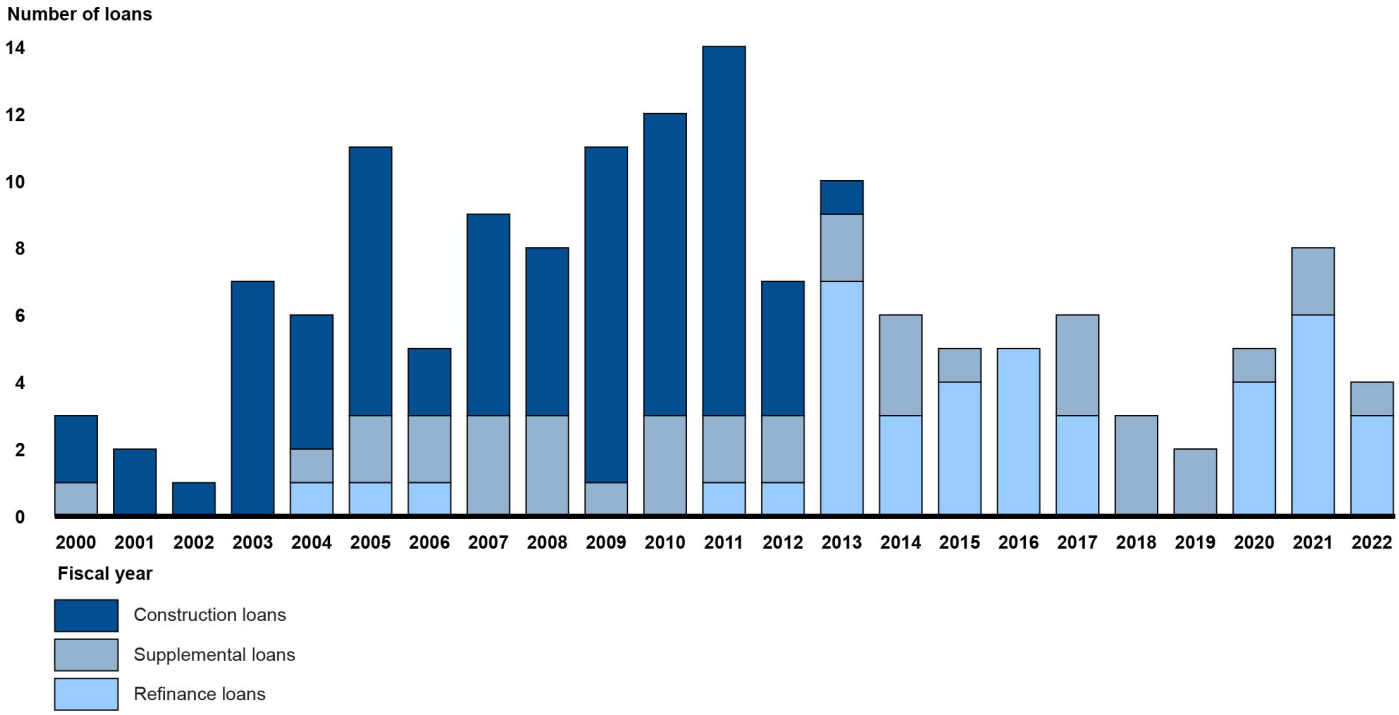
FHA's Hospital Mortgage Insurance Program insured about seven new loans per year on average from fiscal years 2000 through 2022, but the number, dollar amount, and geographic concentration of those loans fluctuated during that period.

Number and Types of Loans

As shown in figure 1, the number of new loans FHA insured annually varied from fiscal years 2000 through 2022, reaching its peak in fiscal year 2011 (14 loans) and generally declining in subsequent years.[20]

[20]In its first decade of operation—fiscal years 1968 through 1978—the program insured an average of approximately 19 loans per year. Program volume generally decreased throughout the 1980s and 1990s, despite temporary increases.

Figure 1: Number of Loans Insured Annually under FHA's Hospital Mortgage Insurance Program by Loan Type, Fiscal Years 2000–2022



Source: GAO analysis of Federal Housing Administration (FHA) data. | GAO-24-106480

Accessible data for Figure 1: Number of Loans Insured Annually under FHA's Hospital Mortgage Insurance Program by Loan Type, Fiscal Years 2000–2022

Year	Refinance Loans	Supplemental Loans	Construction Loans
2000	0	1	2
2001	0	0	2
2002	0	0	1
2003	0	0	7
2004	1	1	4
2005	1	2	8
2006	1	2	2
2007	0	3	6
2008	0	3	5
2009	0	1	10
2010	0	3	9
2011	1	2	11
2012	1	2	4

Year	Refinance Loans	Supplemental Loans	Construction Loans
2013	7	2	1
2014	3	3	0
2015	4	1	0
2016	5	0	0
2017	3	3	0
2018	0	3	0
2019	0	2	0
2020	4	1	0
2021	6	2	0
2022	3	1	0

Source: GAO analysis of Federal Housing Administration data. | GAO-24-106480

Use of the program varied partly in response to economic conditions and program expansions, as the following examples illustrate.

- **2003.** Program volume increased from one loan insured in fiscal year 2002 to seven loans insured in fiscal year 2003, when Congress authorized a temporary waiver that exempted critical access hospitals from the program's patient-day requirement (see fig. 1).[21] According to FHA officials, Congress enacted the waiver because many critical access hospitals—which may provide a combination of acute care and skilled nursing care—could not otherwise meet the requirement.[22] Three of the loans FHA insured that year were for critical access hospitals. Congress renewed the waiver from 2006 through 2011 and from 2014 through July 2016. Agency officials and industry stakeholders said many critical access hospitals currently seek financing through USDA's Community Facilities programs.[23]
- **2009–2011.** The financial crisis and Great Recession of 2007–2009, as well as related recovery legislation, contributed to an increase in FHA-insured loans from fiscal years 2009 through 2011. The effects of the crises may have limited hospitals' access to other types of financing. For example, prior research found that hospitals had limited

[21]Pub. L. No. 108-91, § 3(a)(1), 117 Stat. 1158,1159 (2003).

[22]Some critical access hospitals employ "swing beds" that can be converted from inpatient care to post-hospital nursing care. A hospital that uses more than one-half of its patient days on post-hospital nursing care would not meet the FHA program's patient-day requirement.

[23]USDA's Community Facilities programs provide grants, loans, and loan guarantees to fund a wide range of essential community facilities, including health care facilities, in eligible rural communities.

access to borrowing and experienced financial distress during the Great Recession.[24]

Additionally, the Build America Bonds program—created by the American Recovery and Reinvestment Act of 2009—subsidized state and local government bonds to incentivize public infrastructure projects, including hospitals.[25] According to FHA officials, Build America Bonds contributed to an increase in new hospital construction loans.

- **2013.** An FHA regulatory revision in fiscal year 2013 led to an increase in refinance loans. Previously, FHA primarily used its authority under Section 223(a)(7) of the National Housing Act to refinance existing FHA-insured Section 241 or Section 242 loans. To provide relief from high borrowing costs resulting from the 2007–2009 financial crisis, FHA exercised its authority under 223(f) of the National Housing Act to allow refinancing of debt not insured by FHA in 2009 and 2010 without requiring any part of the loan to be used for construction or equipment. FHA then codified in regulation the additional refinancing options in fiscal year 2013.[26] FHA officials and a participating lender attributed the increase in loans insured that year to the regulatory change.

  The 2013 expansion also affected program composition, as new loans were predominately refinance loans afterwards. Construction loans accounted for approximately 74 percent of all loans insured from fiscal years 2000 through 2012, while supplemental loans accounted for 21 percent and refinances accounted for 5 percent. Following the Section 223 expansion, refinances accounted for about 65 percent of new business from fiscal years 2013 through 2022. Construction loans accounted for 2 percent and supplemental loans accounted for 33 percent during that period.

- **2014–2022.** From fiscal years 2014 through 2022, program volume was consistently lower than in the years immediately following the 2007–2009 financial crisis and included only supplemental and

[24]Sung Choi, "Hospital Capital Investment During the Great Recession," *Inquiry: A Journal of Health Care Organization, Provision and Financing,* vol. 54 (2017), 10.1177/0046958017708399; Germ?n Izón and Chelsea Pardini, "Cost inefficiency under financial strain: a stochastic frontier analysis of hospitals in Washington State through the Great Recession," *Health Care Management Science,* vol. 20, no. 2 (2017), 10.1007/s10729-015-9349-8.

[25]American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, § 1531, 123 Stat. 115, 358.

[26]78 FR 8330 (Feb. 5, 2013).

refinance loans. FHA insured fewer than seven loans per year from fiscal years 2014 through 2019. The federal funds rate remained at or below 2.4 percent during this period, and hospitals had many inexpensive financing options, according to industry stakeholders we interviewed.[27]

The number of loans FHA insured increased in both fiscal years 2020 and 2021, when hospitals may have been affected by financial distress from the COVID-19 pandemic. For example, prior research indicates that some hospitals experienced lower revenue and higher costs during the pandemic.[28] The low federal funds rate in fiscal years 2020 and 2021 may have incentivized hospitals to lower their costs through loan refinances, which accounted for most of FHA's insurance activity during those years.

Amount Insured

The annual dollar amount of new loans FHA insured under the program fluctuated from fiscal years 2000 through 2022, ranging from a low of about $41 million in fiscal year 2002 (one loan) to a high of about $1.9 billion in 2005 (11 loans) in inflation-adjusted terms.[29] After dropping to about $751 million in fiscal year 2006, the annual dollar amount climbed to about $1.7 billion in fiscal year 2009, then generally declined through fiscal year 2022, when it reached roughly $209 million. From fiscal years 2000 through 2022, FHA insured a total of approximately $17.1 billion in new loans.

The program's insurance-in-force generally increased from fiscal years 2000 through 2011 and subsequently declined through fiscal year 2022.[30] In inflation-adjusted terms, the insurance-in-force rose from about $6.1 billion in fiscal year 2000 to about $11.5 billion in fiscal year 2011, consistent with the general increase in loans insured during that period.

[27]The federal funds rate is the central interest rate in the U.S. financial market. It influences other interest rates, including mortgage rates.

[28]Dhruv Kullar, Amelia Bond, and William Schpero, "COVID-19 and the Financial Health of US Hospitals," *Journal of American Medical Association* vol. 323, no. 21 (2020).10.1001/jama.2020.6269; American Hospital Association, "The Financial Stability of America's Hospitals and Health Systems Is at Risk as the Costs of Caring Continue to Rise," *Cost of Caring* (Apr. 2023). Accessed Oct.25, 2023, https://www.aha.org/costsofcaring.

[29]All dollar amounts in this reporting objective are adjusted to fiscal year 2022 dollars using the Fiscal Year Chain-Weighted Gross Domestic Product Price Index.

[30]Insurance-in-force is the insured portion of the total outstanding loan principal.

The insurance-in-force generally fell from fiscal year 2012 onwards, dropping to about $6.4 billion by the end of fiscal year 2022.

Geographic Concentration

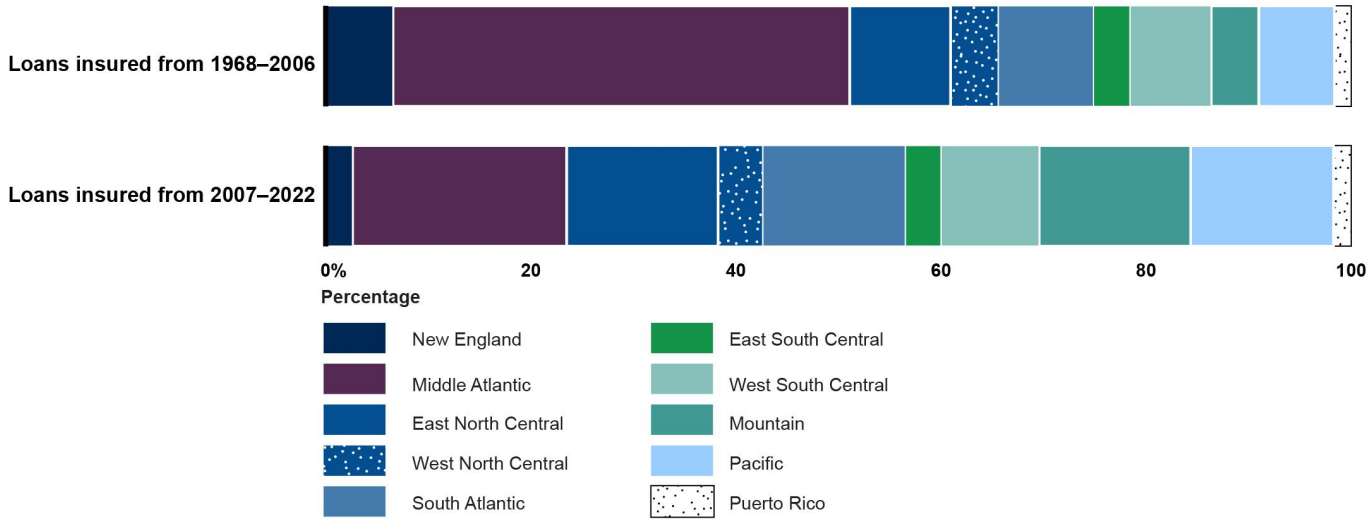
FHA has reduced the geographic concentration of its insurance activity since we last reported on the program in February 2006.[31] Forty-five percent of the loans FHA insured from fiscal years 1968 through 2006 were for hospitals in the Middle Atlantic Census Bureau Division. As we reported in February 2006, 61 percent of the program's unpaid principal balance was concentrated in New York State, exposing the program to state-specific policy and economic conditions. Consequently, our 2006 report recommended that FHA develop a formal strategy to geographically diversify its portfolio. FHA agreed with the recommendation and implemented it in September 2006.

Consistent with the intent of our recommendation, loans to hospitals in other Census Bureau Divisions—particularly the East North Central, Mountain, and Pacific divisions—increased as a share of FHA loans insured from fiscal years 2007 through 2022.[32] Additionally, loans in the Middle Atlantic Division, where New York is located, decreased to 21 percent of loans insured during that period (see fig. 2).

[31]GAO, *Hospital Mortgage Insurance Program: Program and Risk Management Could Be Enhanced*, GAO-06-316 (Washington, D.C.: Feb. 28, 2006).

[32]The Census Bureau groups states into four Regions and nine Divisions. The Divisions include New England, Middle Atlantic, East North Central, West North Central, South Atlantic, East South Central, West South Central, Mountain, and Pacific. As a territory, Puerto Rico does not fall into a Division.

Figure 2: Geographic Distribution of FHA-Insured Hospital Mortgages, by Census Bureau Division



Source: GAO analysis of Federal Housing Administration (FHA) data. | GAO-24-106480

Accessible data for Figure 2: Geographic Distribution of FHA-Insured Hospital Mortgages, by Census Bureau Division

	New England	Mid Atlantic	East North Central	West North Central	South Atlantic	East South Central	West South Central	Mountain	Pacific	Puerto Rico
Loans insured from 1968-2006	6.557	44.536	9.836	4.645	9.29	3.552	7.923	4.645	7.377	1.639
Loans insured from 2007-2022	2.609	20.87	14.783	4.348	13.913	3.478	9.565	14.783	13.913	1.739

Source: GAO analysis of Federal Housing Administration (FHA) data. | GAO-24-106480

Note: We compared these two date ranges because FHA issued a geographic diversity plan in September 2006. The Census Bureau groups states into four regions and nine divisions. As a territory, Puerto Rico does not fall into a division.

Current Participants Are Mostly Standalone and Include Small, Rural, and Critical Access Hospitals

As of May 31, 2023, a total of 61 hospitals or health systems had at least one active loan insured under the Hospital Mortgage Insurance Program. These program participants represented approximately 2 percent of all

hospitals in eligible hospital types as of fiscal year 2020.[33] Thirty percent of the program participants had more than one active FHA-insured loan.

Eighty-five percent (52) of the program participants were standalone hospitals, including many small, not-for-profit, and rural hospitals.[34]

- Nearly two-thirds of the standalone participants were not-for-profit entities, while one-quarter were governmental entities and about one-tenth were for-profit entities.
- Almost 60 percent of standalone participants were small hospitals with fewer than 100 beds. Thirty-five percent were medium-sized hospitals with between 100 and 499 beds, and 6 percent were large hospitals with 500 or more beds.
- One-half of standalone participants were rural hospitals, according to CMS and Federal Office of Rural Health Policy data.[35] Additionally, approximately 31 percent of standalone participants were CMS-designated critical access hospitals, which are often the principal or sole source of health care services in their communities.

The remaining nine program participants (15 percent of the total) were affiliated with health systems. Six of these were part of not-for-profit systems, two were university systems, and one was a for-profit entity. Each system included multiple hospitals that varied in size, location, and type.

According to industry stakeholders we interviewed, hospitals participating in the program fulfill important needs in their communities but may face financing challenges stemming from the characteristics described above. For example, standalone hospitals lack the advantages of system affiliation, including stronger negotiating power and increased access to

[33]According to CMS data, there were 3,305 hospitals in eligible hospital types in fiscal year 2020.

[34]FHA insured loans to some health systems in addition to loans to standalone hospitals. Because systems include multiple hospitals that may differ in size, rural status, and facility type, we describe those characteristics for standalone hospitals only.

[35]We used Federal Office of Rural Health Policy zip code data to determine whether hospitals were in rural locations. That office defines zip codes as rural based on Rural-Urban Commuting Area codes. USDA uses these codes to classify census tracts as urban or rural based on measures of population density, urbanization, and daily commuting.

debt or equity sources.[36] Additionally, industry stakeholders said small or rural hospitals often have limited revenue, which may affect their ability to borrow funds for capital projects. Stakeholders also noted that some program participants are hospitals that lenders would consider too high-risk. These include hospitals affected by natural disasters or those with limited revenue because they serve large numbers of Medicare or Medicaid recipients. According to stakeholders, the Hospital Mortgage Insurance Program provides a way for these hospitals to access financing to fulfill their capital project needs.

Some Characteristics of Ineligible Hospital Types May Limit Financing Options

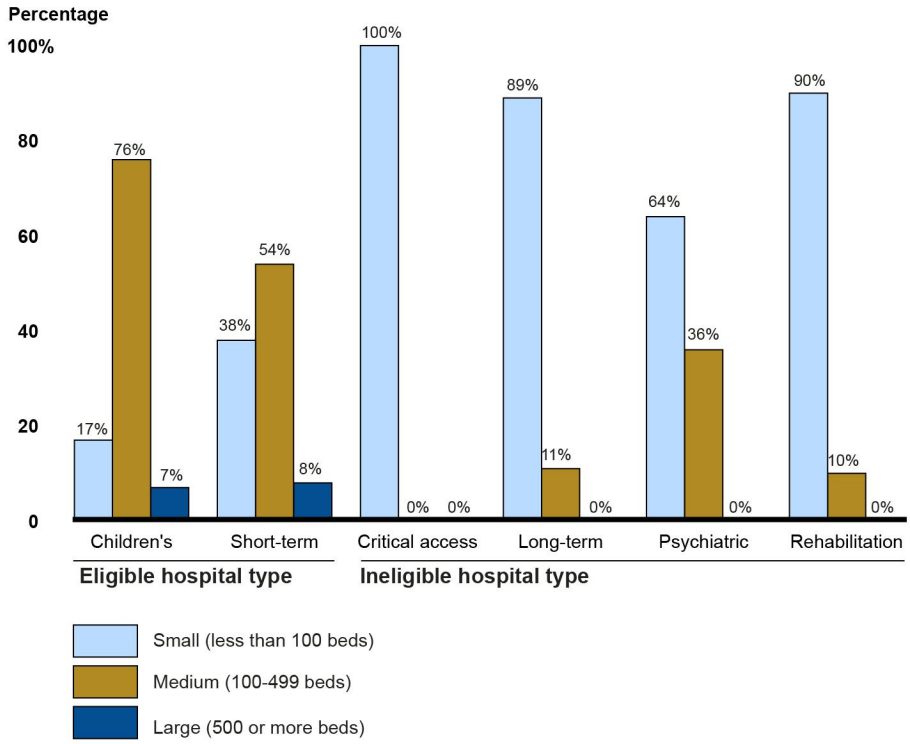
Ineligible Hospital Types Include Many Small, Low-Revenue Facilities

Our analysis of CMS data found that ineligible hospital types are composed of facilities that are, in general, smaller, more likely to be for-profit, and have lower average revenues and profit margins than facilities in eligible hospital types.

Size. In fiscal year 2020, the majority of facilities that composed ineligible hospital types were small, while just one facility—representing a fraction of 1 percent of ineligible hospitals—was large (see fig. 3). In contrast, at least 7 percent of the facilities in each eligible hospital type were large, and most of the remainder were medium-sized. Additionally, in fiscal year 2020, each ineligible hospital type (critical access, long-term, psychiatric, and rehabilitation) averaged fewer than 90 beds per facility. Both eligible hospital types (children's and short-term) each averaged more than 200 beds per facility.

[36]Choi, "Hospital Capital Investment During the Great Recession;" Nathan Carroll, Dean Smith, and John Wheeler, "Capital Investment by Independent and System-Affiliated Hospitals," *Inquiry: The Journal of Health Care organization, Provision and Financing*, vol. 9, no 1 (2015).1177/0046958015591570.

Figure 3: Facility Size by Hospital Type, Fiscal Year 2020



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-24-106480

Accessible data for Figure 3: Facility Size by Hospital Type, Fiscal Year 2020

Facility type	Small	Medium	large
Children's	17	76	7
Short-term	38	54	8
Critical access	100	0	0
Long-term	89	11	0
Psychiatric	64	36	0
Rehabilitation	90	10	0

Source: GAO analysis of Centers for Medicare and Medicaid Services data. | GAO-24-106480

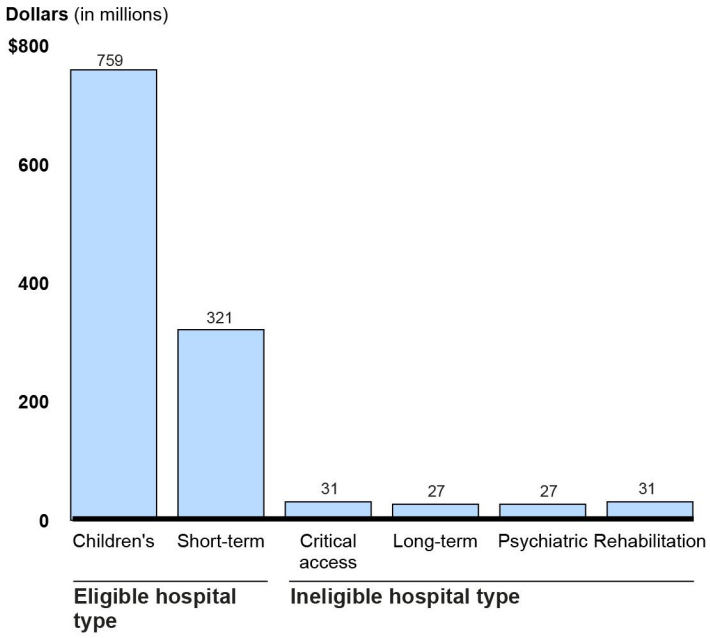
Note: We excluded the 156 state psychiatric hospitals that were open in fiscal year 2020 from this analysis because, according to industry organization officials, these hospitals typically finance capital projects through state appropriations and may not be allowed to carry debt.

Ownership type. In fiscal year 2020, facilities in ineligible hospital types were less likely to be not-for-profit entities and more likely to be for-profit or governmental entities than facilities in eligible hospital types. Among facilities in ineligible hospital types, 38 percent were for-profits, another

38 percent were not-for-profits, and 24 percent were governmental entities. In contrast, 25 percent of the facilities in eligible hospital types were for-profits, 62 percent were not-for-profits, and 14 percent were governmental entities.

Revenue. As shown in figure 4, our analysis of CMS data for fiscal years 2016 through 2020 found that each type of ineligible hospital averaged from about $27 million to $31 million in total annual revenue over that time.[37] In contrast, the two types of eligible hospitals—children's and short-term hospitals—averaged $759 million and $321 million in total annual revenue, respectively, during that period.

Figure 4: Average Total Annual Revenue by Hospital Type, Fiscal Years 2016–2020



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-24-106480

Accessible data for Figure 4: Average Total Annual Revenue by Hospital Type, Fiscal Years 2016–2020

Hospital type	Total annual revenue in millions
Children's	759
Short-term	321

[37]To calculate total revenue, we summed hospitals' net patient revenue and other income. Dollar amounts used to calculate average revenue and profitability in this reporting objective are not adjusted for inflation.

Hospital type	Total annual revenue in millions
Critical access	31
Long-term	27
Psychiatric	27
Rehabilitation	31

Source: GAO analysis of Centers for Medicare and Medicaid Services data. | GAO-24-106480

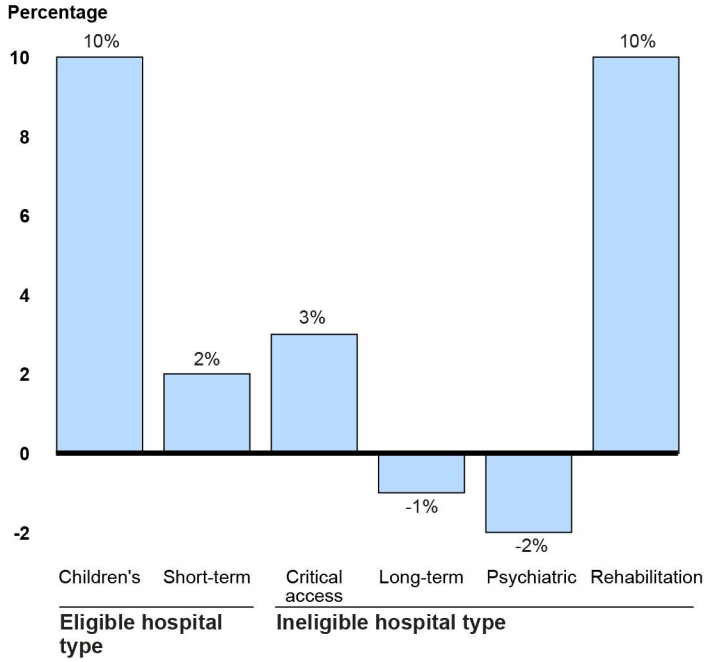
Note: We excluded the 156 state psychiatric hospitals that were open during the 5-year period from this analysis because, according to industry organization officials, these hospitals typically finance capital projects through state appropriations and may not be allowed to carry debt.

In addition to generally lower revenues, some ineligible hospital types, such as psychiatric and rehabilitation hospitals, have less diversified revenue streams than eligible hospital types. For example, because of the exclusion for institutions for mental diseases, psychiatric hospitals may not be able to receive Medicaid reimbursement for inpatient services unless they are in a state that has received a waiver. In addition, while eligible hospital types often perform and are reimbursed for a variety of services, ineligible hospital types are more likely to be specialized and therefore may have fewer potential sources of reimbursement.

Profitability. As shown in figure 5, our analysis of total facility margins—an indicator of hospital profitability—found that two types of ineligible hospitals had the lowest average values during fiscal years 2016–2020.[38] Specifically, long-term care and psychiatric hospitals had average total facility margins of about negative 1 and 2 percent, respectively. The remaining ineligible hospital types (critical access and rehabilitation hospitals) had average total facility margins that were positive, as did both eligible hospital types.

[38]Total facility margin is total revenue minus total costs divided by total revenue. It is a broader measure of hospital profitability than the operating margin measure FHA uses for underwriting purposes. Whereas total facility margin is computed using all revenue and costs, operating margin is computed using only revenue and costs related to patient care.

Figure 5: Average Total Facility Margin by Hospital Type, Fiscal Years 2016–2020



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-24-106480

Accessible data for Figure 5: Average Total Facility Margin by Hospital Type, Fiscal Years 2016–2020

Hospital type	Facility margin in percent
Children's	10
Short-term	2
Critical|access	3
Long-term	-1
Psychiatric	-2
Rehabilitation	10

Source: GAO analysis of Centers for Medicare and Medicaid Services data. | GAO-24-106480

Note: Total facility margin is calculated by subtracting the hospital's total costs from its total revenue and dividing that result by the hospital's total revenue. We excluded the 156 state psychiatric hospitals that were open during the 5-year period from this analysis, because, according to industry organization officials, these hospitals typically finance capital projects through state appropriations and may not be allowed to carry debt.

Smaller, Lower-Revenue Hospitals Can Face Financing Limitations That FHA's Program May Help Address

Hospitals have a variety of options for financing construction or renovation projects and may use multiple funding sources. Common funding sources include a hospital's own cash resources, bond issuances, bank loans and lines of credit, philanthropy, and state and local government appropriations. In addition, federal programs such as FHA's Hospital Mortgage Insurance Program and USDA's Community Facilities Guaranteed Loan Program provide credit enhancements to qualifying hospitals that can help them access affordable financing.[39]

Certain characteristics of ineligible hospital types—primarily their smaller size, revenue, and profitability—can limit their financing options or increase financing costs compared to eligible hospital types. For example, ineligible hospital types may have less ability to

- fund capital projects from operating cash flows and reserves because their smaller revenue bases and lower profitability limit accumulation of cash resources;
- qualify for direct loans or secure public credit ratings needed to issue bonds because their weaker financial performance and less diversified operations (compared to general acute care hospitals) make them higher credit risks;
- access tax-exempt bonds, which generally have lower interest rates than taxable debt, because ineligible hospital types are more likely to be for-profit facilities that do not qualify for tax-exempt debt;
- borrow funds at an affordable cost even if they can qualify for loan or bond financing because lenders and investors demand higher interest rates to compensate for the greater default risk; or
- attract the interest of large investors or lenders because the dollar amounts to be borrowed for the capital improvement projects are

[39]The Community Facilities Guaranteed Loan Program provides loan guarantees to eligible lenders to develop essential community facilities in rural areas with populations of up to 50,000. Among other facility types, the program can be used to construct, enlarge, or improve health care facilities such as clinics, ambulatory care centers, hospitals, rehabilitation centers, and nursing homes. USDA also administers direct loan and grant programs to aid development of essential rural community facilities, including health care facilities.

smaller than what these entities require to achieve their business goals.[40]

To illustrate, organizations with higher credit ratings generally pay less for borrowed funds than organizations with lower ratings, but achieving higher ratings can be difficult for smaller, lower-profit entities. Among other factors, credit rating agencies consider a hospital's operating margins, financial reserves, and scope and breadth of operations when assigning a credit rating. In general, larger margins, reserves, and scales of operation are indicators of credit strength. A stronger credit rating increases the pool of potential lenders, which can improve the price and terms of borrowing and reduce the time and effort needed to secure financing.

Credit enhancements, such as third-party guarantees and insurance, can help smaller or financially constrained hospitals overcome some financing limitations by enhancing the hospitals' creditworthiness. FHA's insurance increases lenders' willingness to lend to lower-credit-quality hospitals because lenders are protected from most losses in the event of default. The FHA credit enhancement also helps lenders offer attractive interest rates by enabling them to sell the loans in the secondary mortgage market, thereby lowering their cost of financing.[41] Additionally, by obtaining an FHA-insured loan, a hospital can receive an investment-grade credit rating for a bond issuance because the reliability of cash flows from the loan are rated on FHA's, not the hospital's, ability to repay the debt.[42] The investment-grade rating lowers the cost of borrowing in the bond market.

However, not all hospitals are eligible for federal credit enhancements offered through FHA's program or USDA's programs for rural areas. Additionally, industry stakeholders said there are fewer private providers

[40]Bonds can be taxable or tax-exempt depending on the issuer, what is being financed with the proceeds of the obligation, and who will be using the bond-financed facilities.

[41]The secondary mortgage market consists of financial institutions and individuals that buy and sell mortgage-backed securities. Many FHA-insured hospital loans are collateral for securities guaranteed by the Government National Mortgage Association (Ginnie Mae), a government-owned corporation within the Department of Housing and Urban Development. Ginnie Mae guarantees the timely payment of principal and interest on securities issued primarily by financial institutions and backed by pools of federally insured or guaranteed mortgages.

[42]Investment grade credit ratings refer to a range of ratings that indicate a relatively low default risk.

of credit enhancements (e.g., private bond insurers) today than there were prior to the 2007–2009 financial crisis.

Uncertainties about Some Ineligible Hospital Types Could Affect FHA's Risks if Program Eligibility Were Expanded

Some Characteristics of Currently Ineligible Hospitals May Add Uncertainty to Underwriting

FHA's underwriting process considers an eligible hospital's historical and projected financial performance and demand for the hospital's services.[43] Applicants must provide financial statements, including balance sheets, income statements, and cash flows, to demonstrate they have adequate revenues to repay a long-term loan. Applicants generally must demonstrate market need, which they can do by citing their occupancy rate, historical market share by major service category, and the number of staffed and licensed beds, among other things.[44] According to FHA, uncertainties related to these factors can reduce confidence in the long-term underwriting decisions required for a mortgage insurance program.

The underwriting uncertainties FHA would face under a program with expanded eligibility would vary by hospital type. For example, FHA has substantial experience with underwriting mortgage insurance for critical access hospitals, as well as related loan performance data, because of the temporary waiver that exempted such facilities from the program's patient-day requirement during several periods since 2003. In contrast, FHA does not have experience with underwriting mortgage insurance for rehabilitation, long-term care, or psychiatric hospitals.

[43]Underwriting is the process of analyzing a borrower's willingness and ability to repay a loan. FHA does not begin the underwriting process until the prospective applicant demonstrates that the hospital meets the patient-day requirement.

[44]In certain cases, such as refinancing under Section 223(a)(7) or 223(f), or a Section 241 supplemental loan application, a study of market need and financial feasibility may not be required or its scope may be limited.

Additionally, psychiatric hospitals may have specific characteristics that would add further uncertainty to FHA's underwriting, as follows:[45]

- **Varying revenue sources and rates.** Revenues of psychiatric hospitals may be hard to predict and could increase uncertainty in FHA's assessment of long-term funding reliability. For example, psychiatric hospitals in some states may have lower Medicaid reimbursement rates than psychiatric hospitals in other states depending on the state's Medicaid policies. Additionally, some states use temporary waivers or other authorities to allow federal reimbursement for treatment of Medicaid enrollees who are patients of institutions for mental diseases.

  In a 2019 report to Congress, FHA identified uncertain revenue sources as a barrier to expanding the program to psychiatric hospitals.[46] FHA noted that revenue sources for psychiatric hospitals lack reliability and predictability because the decision to pursue waivers for the exclusion of institutions for mental diseases varies by state and the time span for any particular waiver is short-term. Hospital industry organizations and stakeholders we interviewed generally agreed that low reimbursement rates contribute to financial challenges for psychiatric hospitals. For example, officials from one behavioral health system said psychiatric hospitals are reimbursed at a lower rate than general acute care hospitals, limiting the extent to which patient revenues can cover capital project costs.

- **Workforce shortages.** Labor shortages among behavioral health providers are a long-standing concern and could heighten psychiatric

[45]Psychiatric hospitals typically offer treatment of substance use disorders in addition to mental health disorders. According to a 2020 federal survey of mental health facilities, 95 percent of psychiatric hospitals offered treatment for co-occurring mental health and substance use disorders plus either serious mental illness in adults or children. Furthermore, 44 percent of psychiatric hospitals offered detoxification (medical withdrawal) services. See Substance Abuse and Mental Health Services Administration, *National Mental Health Services Survey (N-MHSS): 2020 Data on Mental Health Treatment Facilities* (Rockville, MD: Sept. 2021).

[46]In February 2019, Congress directed FHA to evaluate and report on the impact of and barriers associated with expanding eligibility for FHA's mortgage insurance programs for residential care facilities (Section 232 program) and hospitals (Section 242 program) to facilities that primarily provide mental health or substance abuse treatment. Consolidated Appropriations Act, 2019, Pub. L. No. 116-6, 133 Stat. 13; 165 Cong. Rec. H1972-H1973 (Feb. 13, 2019). FHA issued its report in June 2019. Department of Housing and Urban Development, Federal Housing Administration, *Evaluating the Impact of and Barriers Associated with Expanding the 232 and 242 Programs*, Report to Congress (June 2019).

hospitals' long-term financial risks.[47] In our 2022 report on the behavioral health workforce, we identified financial barriers—including low reimbursement rates and compensation—as one category of challenges to recruiting and retaining behavioral health providers.[48] In its 2019 report, FHA said the workforce shortage in the behavioral health industry heightened the risk of long-term funding of psychiatric hospitals. Two hospital industry organizations we interviewed agreed that workforce shortages have increased expenses and financial risks for psychiatric hospitals. For example, representatives of one behavioral health provider we spoke with said they have increased staff salaries and provided incentives for staff to work extra shifts, while patient fees have stayed the same.

- **Uncertain market need.** Changes in behavioral health treatment may complicate the assessment of market need for psychiatric hospitals. In its 2019 report, FHA raised concerns about the market need for psychiatric hospitals as outpatient behavioral health treatment has grown. Consistent with this view, the number of behavioral health beds across private and public hospitals has dropped significantly in the past 60 years. Since the 1960s, behavioral health treatment has shifted from being provided primarily in state psychiatric hospitals to being offered on a continuum of care that includes crisis centers, emergency departments of general hospitals, and outpatient psychiatric services.

  Psychiatric hospitals currently represent a small portion of all mental health facilities. A 2020 federal survey found that psychiatric hospitals accounted for about 5 percent of mental health facilities, while outpatient mental health facilities (the largest category) accounted for about 40 percent.[49] Further, according to a 2022 report by the American Psychiatric Association, the availability of other mental health facilities and resources may serve as alternatives to hospital-level care for an individual and potentially decrease the utilization of inpatient psychiatric hospitals.[50] At the same time, the report cites

[47]Behavioral health providers treat mental health and substance use disorders, among other conditions.

[48]GAO, *Behavioral Health: Available Workforce Information and Federal Actions to Help Recruit and Retain Providers*, GAO-23-105250 (Washington, D.C.: Oct. 27, 2022).

[49]Substance Abuse and Mental Health Services Administration, *National Mental Health Services Survey (N-MHSS): 2020. Data on Mental Health Treatment Facilities* (Rockville, MD: Sept. 2021).

[50]American Psychiatric Association, "The Psychiatric Bed Crisis in the U.S: Understanding the Problem and Moving Toward Solutions" (Washington, D.C.: May 2022).

other community factors that could increase use of psychiatric hospitals, underscoring the complexity of assessing market needs.[51]

Potential Effects of Expansion on Program Participation and Risks Are Unclear

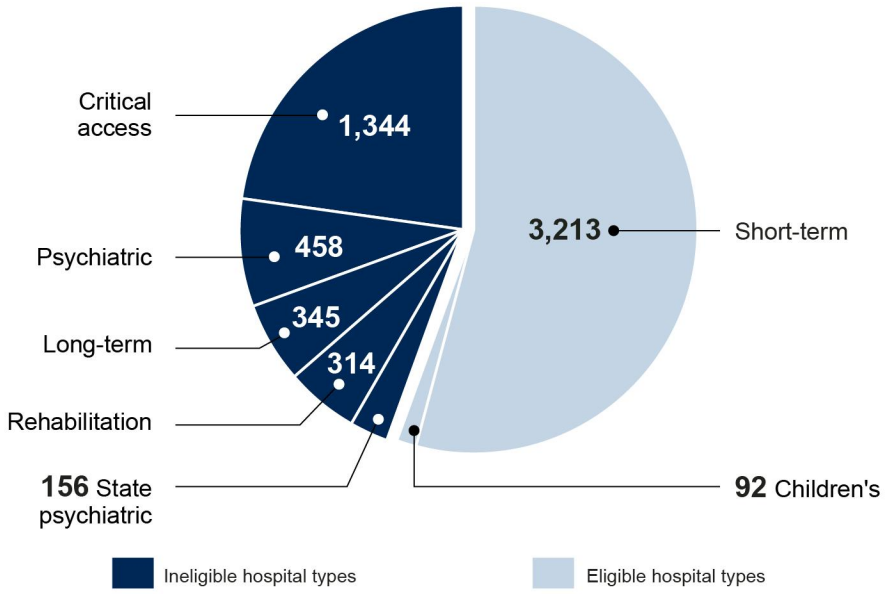
Program Participation

The effects of program expansion on participation are difficult to estimate because the number of additional hospitals that would become eligible for, have interest in, and meet the underwriting requirements of the program is uncertain. Using hospital categories in CMS Cost Reports as a proxy for the program's patient-day requirement, we estimated that about 2,600 additional hospitals could become eligible for the program, based on hospitals open in fiscal year 2020 (see fig. 6).[52] These include more than 1,300 critical access hospitals and more than 600 psychiatric hospitals.

[51]For example, the report states that use of psychiatric hospitals may increase when law enforcement diverts individuals in acute psychiatric crisis to psychiatric hospitals or other treatment centers instead of correctional settings.

[52]Some hospitals included in ineligible hospital types may be eligible for FHA's program based on their patient-day allocations.

Figure 6: Percentage of Hospitals Eligible and Ineligible for FHA's Hospital Mortgage Insurance Program, by Hospital Type (Fiscal Year 2020 Data)



Source: GAO analysis of Centers for Medicare & Medicaid Services data and Federal Housing Administration (FHA) data. | GAO-24-106480

Accessible data for Figure 6: Percentage of Hospitals Eligible and Ineligible for FHA's Hospital Mortgage Insurance Program, by Hospital Type (Fiscal Year 2020 Data)

Eligible or ineligible	Hospital type	Number of hospitals
Eligible hospital types	Short-term	3,213
	Children's	92
Ineligible hospital types	Critical access	1,344
	psychiatric	458
	Long-term	345
	Rehabilitation	314
	State psychiatric	156

Source: GAO analysis of Centers for Medicare and Medicaid Services data and Federal Housing Administration (FHA) data. | GAO-24-106480

Note: We define eligible hospital types as those that generally meet the Hospital Mortgage Insurance Program's patient-day requirement because they primarily provide general acute care services. We define ineligible hospital types as those that generally do not meet the patient-day requirement because of the kinds or mix of services they provide. Although some critical access hospitals may meet the patient-day requirement, we classify critical access hospitals as generally ineligible because congressional waivers that previously allowed broad participation of critical access hospitals have expired. Our eligibility analysis excludes hospitals that are likely to be ineligible for FHA's program for reasons other than the patient-day requirement or for which the facility type was unclear.

However, some of those hospitals may not be interested in or able to use the FHA program depending on their ownership type or other financing options available to them. For example, although about 156 state psychiatric hospitals could become eligible for an expanded program, these hospitals may be unlikely to participate. Industry organization officials said (1) these hospitals typically finance capital projects through state appropriations, (2) state legislatures may be reluctant to pledge state property as collateral as program participation would require, and (3) some hospitals are not allowed to carry debt. More broadly, while the hospital industry groups we interviewed were generally in favor of expanding program eligibility, they were not aware of any estimates of how many currently ineligible hospitals would be interested in using the program.

Furthermore, estimating the number of eligible hospitals that would qualify for loans under an expanded program would require an analysis of individual hospital financial statements FHA receives from loan applicants, but this information is not readily available for all hospitals. These would be necessary to determine whether a hospital meets FHA's regulatory requirements for operating margins and debt-service coverage ratio. Although CMS Cost Reports contain financial information about hospitals, they do not contain the data needed to calculate operating margins in the manner FHA would or to calculate debt-service coverage ratios. Even if operating margins and debt-service coverage ratios were available for all hospitals, FHA reviews other available information on a case-by-case basis to determine whether hospitals qualify for mortgage insurance. This other information includes utilization statistics, project descriptions, and market studies.

Operational Risks

Potential changes in FHA's business activity because of program expansion could strain the operational capacity of FHA's Office of Hospital Facilities, but specific effects would depend on the source and volume of loan applications and on FHA's staff resources. The introduction of new hospital types and the potential for more loan applications could increase demands on FHA's ability to make underwriting decisions and to monitor the loans and hospitals in the insured portfolio.

FHA's Office of Hospital Facilities currently has 23 staff members. However, FHA officials said the office does not have staff with subject matter expertise in all of the hospital types that would become newly eligible under an expanded program. FHA officials said if Congress

extended program eligibility to additional hospital types, FHA would need to hire at least two underwriters and two asset managers with expertise in such hospitals to assess and monitor associated risks. FHA officials further indicated they would need several months to hire and train the staff needed to reach full capacity.

According to FHA, these additional positions would also be needed to help ensure timely review of loan applications and to manage loan monitoring workloads. The Office of Hospital Facilities aims to complete its review of a complete application within 60 to 120 days, depending on the loan type, for 75 percent of applications. According to FHA, the office met its target time frames for 15 of the 19 applications (79 percent) it reviewed from fiscal years 2019 through 2022.[53] FHA officials said if insurance applications increased from recent levels by four per year, additional underwriters and asset managers would likely allow the office to continue meeting target time frames for application processing while adequately monitoring the insured portfolio.

Financial Risks

Expanding eligibility could affect the program's insurance-in-force and credit subsidy rates, but the effects are difficult to estimate without more information on the additional hospitals that might participate.[54] All else being equal, increasing the number of hospitals eligible for the program could increase the number of loans FHA insures, adding to the program's insurance-in-force. At of the end of fiscal year 2022, the insurance-in-force was $6.4 billion. However, how that amount would change after program expansion is unknown because the insurance-in-force depends on multiple factors that are hard to predict. These include the number and size of loans that enter FHA's portfolio in response to market demand and the number and size of loans that exit the portfolio through default or prepayment (e.g., due to borrower refinancings).

Program expansion would also have uncertain effects on the credit subsidy rates of future loan cohorts and may initially make estimating these rates harder. As of October 2023, the reestimated credit subsidy rates for the fiscal year 2018 through fiscal year 2022 loan cohorts were

[53]The target time frames are for applications that have passed FHA's preliminary review.

[54]An agency's credit subsidy costs can be expressed as a rate. For example, if an agency commits to guarantee loans totaling $1 million and has estimated that the present value of cash inflows will exceed the present value of cash outflows by $15,000, the estimated credit subsidy rate is negative 1.5 percent.

all negative (ranging from negative 5.78 percent to negative 8.73 percent), indicating they are estimated to generate subsidy income.[55] Additionally, the original credit subsidy rate for the fiscal year 2023 cohort—which had not been reestimated at the time of our review—was negative 5.73 percent.

If the program were expanded, FHA would need to forecast loan defaults, claims, and prepayments for hospital types with which it has limited or no experience to estimate credit subsidy rates for new loan cohorts. As a result, FHA's credit subsidy estimates may initially be less reliable than before because historical loan performance data are generally a major input to credit subsidy estimation models. Additionally, compared with some other FHA programs, the hospital program insures a relatively small number of large loans.[56] Consequently, the hospital program's credit subsidy rates are potentially more sensitive to small changes in the number of defaults and claims than the rates for other programs. Sensitive and potentially less-certain credit subsidy estimates, coupled with the potential for growth in the insurance-in-force, highlight the challenge of prudently managing a program expansion.

FHA officials identified steps they would take to estimate and mitigate potential financial risks of expanding the program to currently ineligible hospital types. FHA officials said they would consult with entities such as USDA and credit rating agencies that have experience with or loan performance data on those hospitals. FHA officials also said they would revise their credit subsidy estimation models to incorporate any data they could obtain on these additional hospital types. Further, the officials said they would potentially revise program underwriting requirements to mitigate any additional potential risks of insuring loans to such hospitals.[57]

[55]For prior years, FHA incorporated hospital program loans into credit subsidy estimates for the General Insurance and Special Risk Insurance Fund as a whole, but it did not produce program-specific estimates.

[56]The average size of active loans was about $97 million as of May 2023.

[57]When Congress authorized a statutory waiver for critical access hospitals in 2003, FHA initially revised its underwriting requirements to mitigate perceived risks. For example, FHA officials said they required critical access hospitals to contribute to a mortgage reserve fund (a financial cushion against potential defaults) monthly instead of quarterly as required for other hospitals. Additionally, FHA required critical access hospitals to maintain a more conservative reserve schedule than it did for other hospitals. FHA subsequently standardized the mortgage reserve fund requirement for all hospitals.

Previous Methods Used in FHA Programs Could Mitigate Risks of Program Expansion

Prior practices Congress has used to help manage risks posed to FHA programs during periods of change may be applicable to expanding the Hospital Mortgage Insurance Program. Such practices include limiting the volume of FHA's insurance activity and evaluating lessons learned before easing restrictions, and establishing enhanced monitoring and oversight mechanisms. For example, FHA's program for insuring home equity conversion mortgages—a type of reverse mortgage—began as a pilot with limited availability. Through statute, Congress initiated the program in 1988 as a demonstration program that authorized FHA to insure 2,500 reverse mortgages.[58] Congress also required FHA to perform a series of evaluations of the demonstration program, which included discussions of potential lessons learned, such as successes and areas for improvement. Congress made the program permanent in 1998 and subsequent legislation increased the number of authorized loans several times[59]

Congress also began requiring FHA to report regularly on the performance of FHA's largest insurance fund—the Mutual Mortgage Insurance Fund—during a period of rapid change. Following the 2007–2009 financial crisis, FHA experienced a dramatic increase in its market role due to the contraction of other mortgage market segments and a weakening in the performance of its insured single-family mortgage portfolio. The Housing and Economic Recovery Act of 2008 required FHA to provide quarterly reports to Congress on projections of the Mutual Mortgage Insurance Fund's characteristics and performance to ensure that increases in risk were identified and mitigated.[60] FHAs quarterly reports include information on the volume of new insurance activity, borrower risk characteristics, and several loan performance measures such as default rates and predicted and actual insurance claims.

[58]Housing and Community Development Act of 1987, Pub. L. 100-242, § 417, 101 Stat. 1815, 1908 (1988) (codified as amended at 12 USC § 1715z-20).

[59]Departments of Veteran Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1999, Pub. L. No. 105-276, § 593, 112 Stat. 2461, 2654-2655 (1998). Most recently, the Department of Defense Appropriations Act, 2007, Pub. L. No. 109-289, § 131, 120 Stat. 1257, 1316 (2006) increased the number of loans to 275,000.

[60]Housing and Economic Recovery Act of 2008, Pub. L. No. 110-289, § 2118, 122 Stat. 2654, 2833-2835 (2008).

Adopting these practices could help manage the uncertainties and potential risks of expanding the Hospital Mortgage Insurance Program by monitoring or limiting FHA's financial exposure and by providing Congress timely information for oversight and decision-making.

Conclusions

FHA's Hospital Mortgage Insurance Program has a limited market presence but has been an important financing option for some hospitals, particularly during times of economic turmoil. The recent proposal to extend program eligibility to additional hospital types highlights the challenge of serving the capital needs of hospitals with higher credit risks, while managing financial risks to the federal government. Uncertainty about how many and which types of hospitals would participate in the program if the patient-day requirement were eliminated makes it difficult to assess those risks. Also, differences between the hospitals that would become eligible and the hospitals FHA has historically served could reduce FHA's confidence in its underwriting decisions and credit subsidy estimates until it gained experience with the new hospital types. Prior congressional actions to help manage FHA's risks during periods of change may be applicable to the proposed program expansion. For example, requiring enhanced reporting on loans to new hospital types, or initially limiting the volume of such loans through a pilot program, could help ensure that the risks of program expansion are effectively monitored, controlled, and evaluated.

Matter for Congressional Consideration

Congress should consider, if it decides to expand eligibility for FHA's Hospital Mortgage Insurance Program by eliminating the patient-day requirement, adopting practices to help manage risks to the program. For example, Congress could consider (1) requiring FHA to regularly report on program activity, including the number, characteristics, and performance of insured loans to newly eligible hospital types and (2) limiting the volume of insured loans to newly eligible hospital types, such as through a pilot program, and requiring FHA to evaluate lessons learned before easing volume restrictions. (Matter for Consideration 1)

Agency Comments

We provided a draft of this report to the Department of Housing and Urban Development and USDA for their review and comment. The agencies had no comments on the draft report.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Housing and Urban Development, the Secretary of Agriculture, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

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

Jill Naamane
Director, Financial Markets and Community Investment

Appendix I: Objectives, Scope, and Methodology

Our objectives were to examine (1) usage of the Federal Housing Administration's (FHA) Hospital Mortgage Insurance Program from fiscal years 2000 through 2022 and the factors that contributed to changes in size and participation, (2) characteristics of ineligible hospital types and their potential effect on these hospitals' financing options, and (3) potential effects of extending eligibility to ineligible hospital types on program participation and risks.[1]

Literature Search and Interviews

For all objectives, we conducted a literature search for information on (1) financing options and factors that affected the broader hospital financing market since 2013; (2) financing challenges faced by the types of hospitals generally ineligible for FHA's program, such as behavioral health and rehabilitation hospitals; and (3) perspectives on the role of FHA's program and on potential program expansion. We identified articles from peer-reviewed journals, industry and nonprofit publications, and other sources from a search of databases that included ProQuest and EBSCO. We summarized findings from these articles and used the information to provide subject matter context and examples of factors that may have affected the use of FHA's program.

We also selected and interviewed the following federal officials and industry stakeholders to represent a range of entities involved in or potentially affected by changes to FHA's program:

- **FHA.** We interviewed officials from the Office of Health Care Programs and Office of Risk Management and Regulatory Affairs about various aspects of the program's operations—including usage, costs, risk mitigation, and staffing—and the potential effects of extending program eligibility to other hospital types.
- **Department of Agriculture.** We interviewed officials from the Office of Rural Development about the extent to which its community

[1]We classified types of hospitals as eligible and ineligible based on discussions with FHA officials and hospital industry stakeholders, and on analysis of the characteristics of hospitals in FHA's insured portfolio.

facilities programs provide loans and loan guarantees to hospitals, including hospital types that would become eligible for an expanded FHA program.[2]

- **Selected program participants.** We interviewed representatives of four lenders (AMS Health Care Mortgage Corporation, Berkadia Commercial Mortgage, KeyBanc Capital Markets, and Wells Fargo), three hospital financing consultants (Wipfli LLP, FORVIS LLP, and an independent consultant), and one law firm that has worked with lenders on FHA applications since the program began (Krooth & Altman LLP). We selected these entities based on their recent participation in the FHA program to obtain information about factors affecting program use and perspectives on potential program expansion. We also interviewed an appraiser with recent FHA program experience (from Integra Realty Resources) and three appraisers experienced in appraising hospital types not eligible for FHA's program (from Cushman & Wakefield and BBG Real Estate Services) about valuation of hospitals for loan underwriting. We selected these entities based on prior program participation and recommendations from other industry stakeholders.
- **Health care industry stakeholders**. We interviewed representatives from 10 health care associations, including those that represent hospital types ineligible for FHA's program. These were America's Essential Hospitals, American Hospital Association, American Medical Rehabilitation Providers Association, Healthcare Financial Management Association, National Association of Behavioral Healthcare, National Association of Long Term Hospitals, National Association of State Mental Health Program Directors, National Council for Mental Well-being, National Rural Health Association, and Western Psychiatric State Hospital Association. We also interviewed Kaufman Hall, a health care data analysis and management consulting firm. We selected these organizations based on their focus on hospitals or behavioral health. Additionally, we interviewed representatives of two behavioral health systems (Centerstone and Sheppard Pratt) based on recommendations from other industry stakeholders. These stakeholder interviews focused on the financing options, financial condition, and capital improvement needs of hospitals.

[2]The Department of Agriculture's community facilities programs offer direct loans, loan guarantees, and grants to develop or improve essential public services and facilities in communities across rural America, including hospitals.

- **Credit rating agencies.** We interviewed representatives of the three largest credit rating agencies—S&P Global Ratings, Moody's Investors Service, and Fitch Ratings—about their hospital credit rating methodologies, the effect of FHA insurance on those ratings, and hospitals' use of the bond markets for financing capital improvements.

Analysis of Hospital Data and Classification of Eligible and Ineligible Hospitals

For all objectives, we analyzed hospital data from the Centers for Medicare & Medicaid Services' (CMS) Healthcare Provider Cost Reporting Information System (Cost Report data). This system compiles information that CMS requires Medicare-certified hospitals to submit each fiscal year, including information on facility characteristics and finances. Because nearly all hospitals receive Medicare payments, these data effectively represent the entire U.S. hospital population. Parts of our work used data for fiscal year 2020 only (the most recent complete year of Cost Report data available at the time of our analysis) and other parts used 5 years of data (fiscal years 2016 through 2020). The fiscal year 2020 data set included 6,057 hospitals prior to adjustments we made for scoping and data reliability purposes. The 5-year data set, which represents hospitals that were open at least 1 year during that period, included 6,377 hospitals prior to adjustments we made for scoping and data reliability purposes. Our use of and adjustments to these two data sets are discussed further below.

The implications of eliminating the FHA program's patient-day requirement depend partly on the numbers and types of hospitals that are currently ineligible but might become eligible if the program were expanded. We used the fiscal year 2020 Cost Report data set to separate hospitals by facility type and to classify them as eligible or ineligible for the program based on that characteristic. Although FHA evaluates compliance with the patient-day requirement on a case-by-case basis, we used facility type as a general indicator of program eligibility because (1) industrywide data on hospital patient-day allocations are not readily available and (2) reasonable inferences can be drawn about a hospital's ability to meet the patient-day requirement based on the primary services it provides.

Based on inferences about facility types, discussions with FHA officials and hospital industry stakeholders, and analysis of the characteristics of hospitals in FHA's insured portfolio, we classified short-term and children's hospitals as eligible types and long-term, critical access, rehabilitation, and psychiatric hospitals as ineligible types. These

classifications are approximations of eligibility because some hospitals within our ineligible category may be able to meet the patient-day requirement, and some hospitals within our eligible category may not.

We excluded from our eligibility analysis hospitals that were likely ineligible for FHA's program for reasons other than the patient-day requirement. Specifically, we excluded religious nonmedical hospitals because they likely do not meet the statutory requirement to provide inpatient medical care.[3] We excluded federally owned hospitals because they likely do not meet the statutory requirement to be state-licensed or regulated.[4] We also excluded a small number of hospitals participating in CMS demonstration projects, because it was unclear how to classify their eligibility without more information about facility type. Some hospitals submitted multiple cost reports in fiscal year 2020; for data reliability purposes, we excluded those duplicates to ensure that each hospital appeared only once. In total, we excluded 135 hospitals from the fiscal year 2020 data set, leaving 5,922 hospitals included in our eligibility analysis.

For our comparison of the characteristics of eligible and ineligible hospital types in our second objective, we used the 5-year data set for size, ownership, revenue, and profitability comparisons. In addition to the scoping exclusions described above, we removed state psychiatric hospitals from the data for our analyses in the second objective because, according to industry stakeholders, many of those hospitals would be unlikely to use FHA's program even if elimination of the patient-day requirement made them eligible.[5] Excluding the 163 state psychiatric hospitals that were open for at least 1 year within this period left 6,141 hospitals in the 5-year data set prior to additional adjustments we made for data reliability reasons described below.

To determine the reliability of the CMS data we used across our objectives, we (1) reviewed related documentation such as the data dictionaries and filing instructions; (2) reviewed prior GAO interviews with knowledgeable CMS officials and prior GAO reliability assessments of the Cost Report data; and (3) conducted electronic tests for missing, duplicate, and erroneous data.

[3]12 U.S.C. 1715z-7(b)(1)(A)

[4]12 U.S.C. 1715z-7(b)(1)(C)

[5]Representatives of state psychiatric hospital associations said many of their members would be unlikely to use FHA's program because these hospitals typically finance capital projects through state appropriations and may not be allowed to carry debt.

As a result of those electronic tests, we adjusted the 5-year data set used in objective 2 as follows:

- We excluded hospitals that did not report their revenue or that reported abnormally low or negative revenue, likely in error. Specifically, we removed the 232 hospitals that had less than $5 in total revenue over the 5-year period.
- Some hospitals submitted multiple cost reports covering periods shorter than 12 months in the same federal fiscal year. In those cases, we combined the individual reports to create one year-long report and to ensure that each hospital appeared in the data only once per federal fiscal year. We dropped hospitals whose multiple report submissions in a fiscal year covered a period greater than 14 months because those submissions were likely erroneous. These adjustments led to the removal of 289 hospitals from the data.

In total, we removed 514 hospitals through these two adjustments, leaving 5,638 hospitals in the 5-year data set.[6]

We determined the CMS Cost Report data we used for our objectives were sufficiently reliable for purposes of classifying hospitals based on facility type and describing basic characteristics and selected financial metrics of those hospitals.

FHA Program Usage

To describe usage of the Hospital Mortgage Insurance Program, we analyzed data from the FHA Subsidiary Ledger (a core FHA financial management system) for fiscal years 1968 through 2022. We calculated the number and dollar amount of loans insured per year and by loan type (construction, supplemental, or refinance).[7] We grouped loans by state into the nine U.S. Census Bureau divisions to compare the geographic concentration of FHA's insurance activity in two periods—fiscal years

[6]Seven hospitals were affected by both adjustments. For example, a hospital could have been dropped for reporting zero revenue and for submitting cost reports that covered a period greater than 14 months.

[7]The loan types correspond to the subprograms that comprise the Hospital Mortgage Insurance Program. The subprograms are authorized by different sections of the National Housing Act. We classified loans insured under Section 242 of the act as construction loans, loans insured under Section 241 as supplemental loans, and loans insured under Section 223(a)(7) and Section 223(f) as refinance loans.

1968–2006 and fiscal years 2007–2022.[8] We chose those periods because FHA issued a geographic diversity plan in September 2006 to help address the risks of an insurance portfolio that was concentrated in the Middle Atlantic Division and in New York State in particular. We also obtained and analyzed data from FHA on the program's insurance-in-force (the insured portion of the total outstanding loan principal) from fiscal years 2000 through 2022. We adjusted mortgage amount and insurance-in-force data for inflation to fiscal year 2022 dollars using the Fiscal Year Chain-Weighted Gross Domestic Product Price Index.

To describe the characteristics of hospitals participating in FHA's program, we supplemented FHA's data with fiscal year 2020 Cost Report data. For hospitals with active FHA-insured loans as of May 31, 2023, we used the CMS Certification Numbers (unique hospital identifiers) provided by FHA officials to obtain Cost Report information on those hospitals.[9] This information included whether each participant was a standalone or system hospital, as well as the ownership type (for-profit, not-for-profit, or government), facility type (children's, critical access, long-term, psychiatric, rehabilitation, or short-term), and size (number of beds) of standalone participants as of fiscal year 2020.[10] Lastly, we used zip code data from the Health Resources & Services Administration's Federal Office of Rural Health Policy to identify standalone participants meeting that agency's definition for rural hospitals.[11] Because system hospitals include multiple facilities that may differ in size, type, and rural status, we only reported on ownership type for these participants.

We assessed the reliability of the FHA data by (1) conducting electronic tests for missing, duplicate, and erroneous data; and (2) obtaining written responses from knowledgeable FHA officials on the systems and methods they used to collect the data. We determined the data were

[8]The Census Bureau groups states into four regions and nine divisions. The divisions include New England, Middle Atlantic, East North Central, West North Central, South Atlantic, East South Central, West South Central, Mountain, and Pacific.

[9]CMS Certification Numbers are six-digit identifiers with information on facility type that CMS assigns to institutional providers for payment purposes.

[10]We defined hospitals with fewer than 100 beds as small, hospitals with between 100 and 499 beds as medium, and hospitals with 500 or more beds as large.

[11]We used Federal Office of Rural Health Policy zip code data to determine whether hospitals were in rural locations. That office defines zip codes as rural based on Rural-Urban Commuting Area codes. The Department of Agriculture uses these codes to classify census tracts as urban or rural based on measures of population density, urbanization, and daily commuting.

sufficiently reliable for the purposes of describing the volume and geographic concentration of FHA's insurance activity. We leveraged prior GAO data reliability assessments that determined that the Federal Office of Rural Health Policy data were sufficiently reliable for identifying rural hospitals by zip code.

Characteristics of Ineligible Hospital Types That May Affect Financing Options

To describe characteristics of ineligible hospital types and their potential effect on these hospitals' financing options, we reviewed relevant research literature (identified through the steps discussed earlier); interviewed the hospital industry stakeholders, program participants, and credit rating agencies cited above; and analyzed CMS Cost Report data.

Subject to the exclusions and adjustments described earlier, we analyzed the 5-year Cost Report data set to calculate descriptive statistics about the size, ownership, revenue, and profitability of specific hospital types (children's, rehabilitation, etc.). We calculated the number and percentage of hospitals in each size category (small, medium, or large) and ownership category (for-profit, not-for-profit, or government) for hospitals open in fiscal year 2020, the most recent year in the data set. We calculated average total annual revenue and average total facility margins (revenue minus costs divided by revenue) by facility type across the 5-year period.[12] We then used the program eligibility classifications described earlier to analyze differences between eligible and ineligible hospital types across the different characteristics we examined.

Potential Effects of Program Expansion

To identify the potential effects of extending program eligibility to ineligible hospital types, we reviewed FHA underwriting standards and documents, including the program handbook, application guides, and lender training materials. We also reviewed prior GAO work on FHA's management of the program.[13] Additionally, we reviewed a June 2019 FHA report to Congress on the potential impact of and barriers to expanding the program to behavioral health facilities. Further, we reviewed prior GAO

[12]To calculate total revenue, we summed hospitals' net patient revenue and other income. To calculate total costs, we summed operating expenses and other expenses.

[13]For example, see GAO, *Hospital Mortgage Insurance Program: Program and Risk Management Could Be Enhanced*, GAO-06-316 (Washington, D.C.: Feb. 28, 2006).

work on methods previously used to manage risks in FHA's mortgage insurance programs during periods of change.[14]

We applied the program eligibility classifications described earlier to our fiscal year 2020 Cost Report data set to estimate the number and types of additional hospitals that could become eligible if the program's patient-day requirement were removed. Our estimates are general approximations because the ability of a hospital to meet the patient-day requirement does not always correlate with facility type.

To further examine how eliminating the patient-day requirement might affect program participation, we interviewed industry stakeholders—including associations representing ineligible hospital types—for their perspectives on how many additional hospitals might be interested in using an expanded FHA program. We also explored using CMS Cost Report data or other hospital industry data to estimate how many currently ineligible hospitals could meet two regulatory underwriting standards for operating margin and debt-service coverage ratio. FHA uses these financial metrics, among others, to assess an eligible hospital's ability to qualify for an FHA-insured mortgage.

However, the data did not allow us to reliably calculate these metrics in the same manner as FHA. The audited financial statements that FHA uses to conduct its underwriting analysis are not readily available for all hospitals and may have different reporting requirements than hospital financial information compiled by other entities. Additionally, FHA may adjust how certain revenues and costs are classified to align them to the agency's underwriting standards. Operationalizing these case-by-case determinations across a large hospital data set was infeasible. Because of these limitations, we did not assess how many ineligible hospitals could meet FHA's underwriting standards.

To examine the potential effects of program expansion on FHA's operational risks, we reviewed FHA documents on staffing levels, workload, and performance targets, and interviewed officials from FHA's Office of Health Care Programs. To examine potential financial risks, we reviewed FHA budget and loan performance information, including historical credit subsidy rates for the program and for FHA's General Insurance and Special Risk Insurance Fund.

[14]For example, see GAO, *Mortgage Financing: Actions Needed to Help FHA Manage Risks from New Mortgage Loan Products*, GAO-05-194 (Washington, D.C.: Feb. 11, 2005).

We conducted this performance audit from December 2022 to January 2024 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Steve Westley (Assistant Director), Daniel Newman (Analyst in Charge), Chelsea Carter, Iola D'Souza, Leslie V. Gordon, Garrett Hillyer, Alison Knowles, Daniel Lee, Alberto Lopez, John Milberg, Jena Sinkfield, Farrah Stone, and Juliann Vadera made key contributions to this report.

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