Committee on Healthcare Financing

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Regulations Division, Office of the General Counsel
Department of Housing and Urban Development
451 Seventh Street, S.W., Room 10276
Washington, D.C. 20410

RE: Federal Register Vol. 81, No. 18; January 28, 2016
Docket No. FR-5876-N-02
Changes in Certain Multifamily Mortgage Insurance Premiums

To Whom It May Concern:

I am writing on behalf of the members of the Committee on Healthcare Financing and a coalition of national senior residential and health care associations, which includes the American Health Care Association/National Center for Assisted Living, American Hospital Association, American Seniors Housing Association, Coalition for Healthcare Finance, Greater New York Hospital Association, Healthcare Association of New York State, and LeadingAge,[1] to provide comments on the Department of Housing and Urban Development's ("**HUD**") proposed decrease to several of its mortgage insurance premiums ("**MIP**"), as announced in the referenced Federal Register (the "**Notice**"). We strongly support HUD's efforts to reduce the MIP for affordable and energy-efficient multifamily housing projects, and request that HUD extend that same MIP reduction to its Section 232 and Section 242 mortgage insurance programs.

The Notice makes clear that HUD desires to support this Administration's main "mission priorities: Affordable Housing, and energy efficiency."[2] We believe that HUD can fully realize these *mission priorities* by extending the proposed MIP reduction to HUD's Section 232 and Section 242 programs. Affordable housing is aimed at providing a basic human need—shelter. We believe that health care is another such basic need that HUD has been tasked to address. Since the 1960s, the Section 232 and Section 242 programs have provided affordable financing for hospitals, skilled nursing facilities, and seniors' housing projects that address the basic needs of low-income populations just as significantly as affordable housing projects. In fact, Section 232 projects provide housing that is as critically needed as housing provided through HUD's multifamily programs. Also, both programs can be utilized to promote energy efficient health care facilities. By excluding the Section 232 and Section 242 programs, we believe HUD falls well short of achieving its "mission priorities."

[1] The Committee on Healthcare Financing is an association of investment and mortgage bankers and financial advisors who participate in HUD's Sections 232 and 242 mortgage insurance programs. The other groups listed are national trade associations representing hospitals, and owners and operators of skilled nursing facilities, assisted living facilities, and other seniors' housing projects.
[2] Changes in Certain Multifamily Mortgage Insurance Premiums, 81 Fed. Reg. 4926, 4927 (January 28, 2016).

A. Affordable Housing v. Medicaid Funding Health Care

In the Notice, HUD points to "[m]ultiple recent studies" that discuss the "unprecedented rental affordability crisis facing the country."[3] In focusing on the nation's housing needs within in the sole context of its multifamily housing programs, we believe HUD missed the opportunity to fully support both affordable housing and this Administration's most touted legislative achievement—improving access to affordable health care for the uninsured.

First, Section 232 projects provide housing for our elderly and disabled via skilled nursing facilities, assisted living facilities, and board and care facilities. Therefore, we believe that actions by HUD to encourage affordable housing must include the housing financed by the Section 232 programs. Second, one of the Obama Administration's most significant legislative achievements was passage of the "Affordable Care Act," i.e., the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. One of the main components of the Affordable Care Act was the expansion of Medicaid to enable more low-income and disabled individuals and families to access health care.

We understand that HUD views its main mission as providing affordable housing. However, Congress also bestowed upon HUD the responsibility to lead the Federal Government's efforts to construct and finance nursing homes, assisted living facilities, board and care facilities, and urgently needed hospitals.[4] By virtue of enacting Section 232 and Section 242 of the National Housing Act, we believe that Congress imposed upon HUD a responsibility to support both affordable housing and affordable health care for our nation's poor. Therefore, we believe that the MIP reduction should be modified to include the Section 232 and Section 242 programs, particularly to the extent that the individual projects serve Medicaid patients/residents. We believe that a patient's/resident's use of Medicaid to obtain health care services is no different than an individual who benefits from a Section 8 housing assistance payment contract to obtain housing.

Medicaid was originally enacted in 1965 as a program to provide medical assistance to individuals and families on welfare.[5] Medicaid is "the nation's main public health insurance program for low-income people. Most Medicaid beneficiaries lack access to private insurance and many have extensive needs for care. Medicaid is also the dominant source of long-term care coverage in the U.S. As a major insurer of low-income people, Medicaid provides key financing for the safety-net institutions and providers that serve the low-income and uninsured population, as well as the larger public."[6] With the enactment of the Affordable Care Act, the Obama Administration clearly stated that one of its "mission priorities" would be providing affordable health care to our nation's poor. We ask HUD to support that priority.

HUD is in the unique position of being able to help this Administration meet its health care and affordable housing priorities within HUD's existing mandates. We believe that HUD's ability to support affordable health care for low-income families is as important to HUD's support of affordable housing. Without access to affordable housing and health care, our nation's low-income families will remain entrenched in poverty for another generation.

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[3] *Id*.
[4] See Section 232 (12 U.S.C. 1715w) and Section 242 (12 U.S.C. 1715z-7) of the National Housing Act.
[5] The Kaiser Commission on Medicaid and the Uninsured, *Medicaid: A Primer* (March 2013).
[6] *Id*. at page 1.

State governments would experience considerable fiscal benefits that would come with a targeted reduction in MIP rates for Section 232 and Section 242 insured loans. The cost of Medicaid "is shared by the federal government and the states. The federal government matches state Medicaid spending based on a formula specified in the Social Security Act. By statute, the federal match rate is at least 50% in every state, but the lower a state's per capita income, the higher the federal match rate it receives."[7] By reducing the MIP rates for those Section 232 and Section 242 projects that service Medicaid patients/residents, HUD will relieve pressure on both Federal and State reimbursement budgets. Moreover, by lowering the cost of capital via reduced MIP rates, Medicaid reimbursement could be reallocated from debt service to patient care, programs, and other services, creating a more efficient use of Federal and State dollars.

Therefore, to fully realize its mission priority of providing for the basic needs of the poor, we suggest the following changes to the Notice:

1. Section 232 projects that have (a) 70%+ of their resident days attributable to residents receiving Medicaid, or any state equivalent[8], (b) 90%+ of units covered by a Section 8 Project Based Rental Assistance (PBRA) contract or other federal rental assistance program contract serving very low-income residents, with a remaining term of at least 15 years, or any such agreement to extend the term to at least 15 years as part of the Section 232 financing, or (c) 90%+ of their units covered by an affordability use restriction under the Low Income Housing Tax Credit program or similar state or locally sponsored program, and with a recorded regulatory agreement in effect for at least 15 years after final endorsement and monitored by a public entity will have a MIP of 25 bps;
2. Section 232 projects that have (a) between 10-70% of their resident days attributable to residents receiving Medicaid, or any state equivalent, (b) between 10-90% of units covered by a Section 8 Project Based Rental Assistance (PBRA) contract or other federal rental assistance program contract serving very low-income residents, with a remaining term of at least 15 years, or any such agreement to extend the term to at least 15 years as part of the Section 232 financing, or (c) between 10-90% of their units covered by an affordability use restriction under the Low Income Housing Tax Credit program or similar state or locally sponsored program, and with a recorded regulatory agreement in effect for at least 15 years after final endorsement and monitored by a public entity will have a MIP of 35 bps;
3. Section 242 projects that have 50%+ of their patient days attributable to patients receiving Medicaid, or any state equivalent, will have a MIP of 25 bps; and
4. Section 242 projects that have between 10-50% of their resident days attributable to patients receiving Medicaid, or any state equivalent, or an alternative affordable attribute will have a MIP of 35 bps. For the "alternative affordable attribute" we suggest that the following characteristics of a Section 242 project should be considered the equivalent of an affordable housing project:
   (a) Any hospital classified as a "Safety Net Hospital"[9];

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[7] *Id*. at page 5.
[8] Many states are shifting to managed care for Medicaid, so we suggest allowing for such programs when determining affordability compliance.
[9] "A safety net hospital or health system provides a significant level of care to low-income, uninsured, and vulnerable populations. Safety net hospitals are not necessarily distinguished from other providers by ownership – some are publicly owned and operated by local or state governments and some are non-profit. Rather, they are distinguished by their commitment to provide access to care for people with limited or no access to health care due to their financial circumstances, insurance status, or health condition." Larry S. Gage, National Association of Public Hospital and Health Systems, *What is a Safety Net Hospital*

(b) Any hospital classified as a "Sole Community Provider"[10];
(c) Any hospital that provides graduate medical education programs in which at least four (4) physicians are trained/enrolled; or
(d) Any hospital with a Critical Access Hospital designation.

5. Section 223(e) projects will have a MIP of 25 bps.

B. Energy Efficiency

In the Notice, HUD references President Obama's Climate Action Plan as a source for the President's and HUD's "goals to reduce energy consumption and utility costs throughout the building sector."[11] We believe that the projects financed with HUD's Section 232 and Section 242 programs can and often do upgrade or construct building projects that satisfy today's industry recognized standards for green buildings. Because Section 242 projects (and in many cases Section 232 projects as well) are much larger than a multifamily housing project, the environmental impact of an energy efficient Section 242 or Section 232 project can be tremendous. By excluding these projects, HUD will miss an easy opportunity to encourage energy efficient construction within all of its loan programs. Therefore, we suggest the additional changes to the Notice:

1. Amend the FHA Multifamily Mortgage Insurance Premium by Rate Category Chart, to add under the category "Green/Energy Efficient Housing" the following programs:
   (a) 232 NC/SR with Green;
   (b) 232/241 NC/SR with Green;
   (c) 232/223(f) Refinance or Purchase with Green;
   (d) 242 NC/SR with Green;
   (e) 242/241 NC/SR with Green;
   (f) 242/223(f) Refinance or Purchase with Green.

(http://literacynet.org/hls/hls_conf_materials/WhatIsASafetyNetHospital.pdf). Safety net hospitals receive Hospital Disproportionate Share Payments from the Centers for Medicaid and Medicare Services ("CMS") to help offset the cost of caring for large numbers of low-income patients.

[10] Sole community hospitals are located in rural areas. CMS requires that sole community hospitals be located long distances from other like hospitals, e.g., 15-30 miles depending on certain other requirements. Other limitations on sole community hospitals may include being limited to 50 beds, because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years, or because of distance, posted speed limits, and predictable weather conditions, the travel time between the sole community hospital and the nearest like hospital is at least 45 minutes. *See* 42 C.F.R. §412.92 (2015).

[11] Changes in Certain Multifamily Mortgage Insurance Premiums, 81 Fed. Reg. 4926, 4927 (January 28, 2016).

C. Program Soundness

In a letter to HUD dated May 10, 2012, we requested of HUD not to increase the MIP for Fiscal Year 2013.[12] A summary of our case is as follows:

> Congress has mandated, in the Federal Credit Reform Act of 1990, "that administrative costs associated with loan guarantee programs be paid from discretionary appropriations rather than being reflected in the credit programs financing." Thus, if the General Insurance/Special Risk Insurance (GI/SRI) Fund attributable to the Section 232 and Section 242 programs are adequately protected and the effect of the proposed MIP increase is simply to raise money for the general treasury, then the MIP increase is counter to Congressional mandates and the Federal Credit Reform Act of 1990.[13]

Unfortunately, HUD denied our 2012 request, and increased MIPs for all Section 232 and Section 242 projects.

Since 2012, the default rate for the Section 232 and Section 242 programs have remained low and in fact have fallen, despite the country coming out of the Great Recession. HUD has confirmed the Section 232 and Section 242 programs' soundness by giving both programs a -5%+ credit scoring in its Fiscal Year 2017 budget proposal.[14] That is nearly twice as favorable as the credit scoring for the multifamily loan programs. To put this scoring in perspective, when HUD raised the MIP in 2012, it predicted that the increased MIP would improve the credit scoring as follows: Section 232 loans would improve from -1.34 to -2.51%, Section 232/223(f) loans would improve from -1.96 to -4.45%, and Section 242 loans would improve from -3.82 to -6.56%.[15] Therefore, from a risk perspective, we believe that the MIP rates for both Section 232 and Section 242 are too high generally, and can be reduced on the limited basis that we have proposed without jeopardizing the GI/SRI fund.

D. Conclusion

We support HUD and the Administration's efforts to achieve its mission priorities of affordable housing and energy efficiency. However, we believe that HUD falls short of achieving that goal if it continues to exclude the Section 232 and Section 242 programs. Like the HUD housing programs, HUD's Section 232 and Section 242 programs provide a basic need—affordable health care—to a wide sector of the low-income population. Additionally, the Section 232 program provides housing for our seniors and disabled. The Federal Government has long recognized the need to support both affordable housing, through programs such as Section 8 vouchers and LIHTCs, and affordable health care, through Medicaid. Because HUD is uniquely tasked with providing access to both affordable housing *and* affordable health care to low-income families, we believe HUD should enthusiastically embrace this opportunity to fully realize its *mission priorities*. Extending the MIP reduction to HUD's Section 232 and Section 242 programs

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[12] Letter from Roderick D. Owens and Nicole L. Hoffpauir, Committee on Healthcare Financing, to Regulations Division, Office of the General Counsel, Department of Housing & Urban Development (May 10, 2012) (on file with Office of the General Counsel).
[13] *Id.*
[14] *See* U.S. Department of Housing and Urban Development Fiscal Year 2017 Congressional Justifications (https://portal.hud.gov/hudportal/HUD?src=/program_offices/cfo/reports/fy17_CJ).
[15] Federal Register Vol. 77, No. 69.

will do that. Moreover, a reduction in MIP will not adversely affect HUD's credit standing, as the healthcare portfolio has performed soundly and with very acceptable levels of risk.

Thank you for your consideration of our comments and please do not hesitate to call me with any questions.

Very truly yours,

Roderick D. Owens
Executive Director

CC: Dr. Edward L. Golding, Principal Deputy Assistant Secretary, Office of Housing
Mr. Roger Miller, Deputy Assistant Secretary, Office of Healthcare Programs
Members, Committee on Healthcare Financing