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On Behalf of a Coalition of National Healthcare Associations

American Association of Homes and Services for the Aging
American Health Care Association
American Hospital Association
American Seniors Housing Association
Assisted Living Federation of America
Committee on Healthcare Financing
Coalition for Senior Healthcare Reform
Greater New York Hospital Association
National Association of Health and Education Facilities Finance Authorities
National Rural Health Association
National Association of Public Hospitals and Systems

July 27, 2009

The Honorable David Stevens
Assistant Secretary for Housing – Federal Housing Commissioner
Department of Housing and Urban Development
451 Seventh Street S.W. – Room 9100
Washington, D.C. 20410

Dear Commissioner Stevens:

First, we would like to congratulate you on your confirmation as Commissioner. Undoubtedly your tenure will be critical to the Administration's ability to address major American housing challenges, but, as well, to assure access to affordable healthcare capital in support of the President's healthcare reform objectives. In the latter respect, we are writing on behalf of a coalition of national healthcare associations with whom we have worked closely towards improving the effectiveness of FHA's Section 232 Senior Residential and Section 242 Hospital programs, including the Committee on Healthcare Financing, an association of mortgage and investment bankers which have been active in FHA health care programs for nearly three decades. This Coalition believes that in today's troubling economic circumstances, these programs are not only a source of affordable capital may also be seen as a means for preserving neighborhoods and creating job opportunities.

This past summer we were pleased to learn how FHA healthcare programs could be strengthened for those purposes. In that instance, the Office of Insured Health Care Facilities (OIHCF) utilized the Sigma Six LEAN strategy to streamline Section 232's underwriting and asset management functions. That initiative, one we understand is now being implemented for



the Section 242 program, achieved a number of significant program improvements and has realized broad lender and sponsor support despite OIHC's limited staffing. Once the staffing is addressed, we are confident that those results can be accelerated.

More recently, we witnessed a second federal initiative addressing healthcare capital needs per the issuance of a July 1st Notice expanding FHA's Section 223(f) refinancing program to hospitals. That program, as you know, has been successfully utilized to reduce financing costs for multifamily and senior residential projects since the 1980s and may now be used to achieve similar benefits for community hospitals. The new program serves a particularly critical hospital need in view of the financial stresses and instability resulting from a weakened banking sector, the downgrading of bond insurers, and recent Auction and Variable Rate Bond tax-exempt remarketing failures.

We were, of course, particularly pleased that the Notice was issued for immediate effect, although we understand that a Proposed Rule will be issued shortly to permit public comment. While we certainly intend to submit comments once that rule is published, we are also aware that converting a Proposed to a Final Rule is a complex, time consuming process. As such, we are concerned that several important industry concerns we have currently identified may not be resolved for several months if we were to rely on the regulatory process alone. While we reluctantly raise these concerns so soon after you have joined the Department, in view of the urgent needs the Notice addresses, we believe that to be necessary.

Our specific concerns regard certain eligibility standards which may on their face and unintentionally limit program access to otherwise creditworthy facilities. Those standards, set forth in Subsection 4(a)(2)(iii), in effect raise baseline thresholds above those currently used for underwriting inherently riskier (from a real estate perspective) new construction projects, since those projects are subject to unknown construction escalations and delays and market uncertainty. Frankly, we cannot identify a logical basis for this result in a refinancing program. The standards in question are:

- (1) An aggregate Operating Margin for the prior three years exceeding .33% (instead of the current zero based requirement used for new construction projects);
- (2) A Debt Service Coverage Ratio of 1.80 in the prior three fiscal years (instead of 1.25 ratio now used for new construction projects); and
- (3) A new requirement that the interest rate on debt to be refinanced increased by at least 1% since January 1, 2008, or such an increase is "imminent".

Although Items (1) and (2) alone may limit program access, Item (3) appears most troublesome. If read literally, it can be expected to preclude refinancing of fixed rate debt *per se* and further limit the program's application to the refinancing of Variable Rate Demand Bonds (VRDB), the particular financial structure where the greatest need for the federal refinancing option occurs.

While prior to recent market failures, VRDB financing had been considered a reliable vehicle for financing long term debt (25-35 year maturities) with short-term interest rates (by

effectively tying interest rates to short-term (weekly or monthly) remarketing periods), that conclusion is no longer so obvious. The ability of VRDB financing to achieve short-term low rate interest rates is, as you know, dependent on liquidity provided by the presence of bank letters of credit (LCs) that will assure VRDB holders that their bonds will always be redeemed (*via* the LC) if periodic remarketing efforts fail. The problems now affecting the former smoothly functioning VRDB market began early in 2008, when several major national banks, many of which had provided VRDB LCs, were downgraded, and others simply failed. These events, of course, failed to enamor investors to either banks or VRDB markets. Worse still, as a result of investor concerns with the greater banking community, large numbers of VRDBs became unmarketable, effectively forcing the LC issuer in point to repurchase and hold the VRDBs as bank bonds. The issue was exacerbated when a number of LC providers also indicated an unwillingness to extend their outstanding LCs (typically these LCs had one to three year maturities, far short of the longer 25-35 year bond maturities) and others, international and domestic, indicated they were exiting the liquidity market.

The economic fallout in these circumstances has been severe. Even if VRDBs could be remarketed without LC support (unlikely in the first instance), interest rates would be expected to increase significantly. When not remarketable, as noted, the VRDBs must be repurchased by the LC issuer. In that case, two consequences will typically result. First VRDB interest rates will increase to a pre-determined level. Second and perhaps most troubling, VRDB amortization may be accelerated to significantly shorter timeframes, again increasing annual debt service. These results, compounded by concerns over market instability, of course, are avoided when VRDB obligations can be refinanced into Section 223(f) fixed rate, long term maturities.

As noted above, our concern is that a literal reading of the Notice's eligibility qualifications, absent clarification of their application to existing debt (and VRDBs in particular) is a concern. If interpreted narrowly, the standards are expected to limit the program's availability as a means for reducing debt service and, in the case of cost reimbursed debt, related Medicare and Medicaid reimbursement levels. They also can be viewed to limit FHA's ability to realize additional Mortgage Insurance Premium revenue. While it may well be the Notice's intention to apply its standards in a manner to allow its objectives to be realized, that conclusion is unclear and a matter of concern.

In reviewing this letter, we believe particular attention should be paid to the fact that baseline eligibility criteria now used to underwrite *new construction projects* has consistently allowed Section 242 to be scored at significantly credit negative levels. In fact, the program maintains one of the strongest negative levels in FHA's construction portfolio (-2.51% FY 2009 and an estimated -4.58 FY 2010). Other Section 223(f) financing programs also have significantly negative scoring levels.² In these circumstances, we can find no reasonable basis for applying more restrictive standards to cases where the sole objective is to reduce operating costs of viable hospitals with established markets.

² FY 2009 scoring for Section 223(f) multifamily projects was -3.29; for Section 223(f)/232 healthcare, -2.09%. Estimated Administration FY 2010 credit scoring for Section 223(f) multifamily was set at -3.87%; for Section 223(f)/232 healthcare projects, -2.29%

If, however, staffing and workload concerns which may arise from a potential increase in OIHCF applications are the basis for the Notice's guidelines, we suggest these concerns may be overstated and are certainly overshadowed by the benefits the program offers. Certainly the time and staffing to underwrite refinancings will be significantly less than those for new construction. As well, we understand that FHA, in expectation of the new program, has previously indicated a willingness to increase OIHCF staffing to accommodate projected activity increases. If so, the only predictable impact of the new standards will be to exclude hospitals critically in need of relief without clear benefit to the Department.

For these reasons, we request the Department delete the Notice's Subsection 4(a)(2)(iii) guidelines as unnecessary to protect the federal interest or alternatively clarify their application to the concerns discussed above, including what appears to be an inadvertent exclusion of fixed interest rate refinancing.

We would appreciate the opportunity to meet with you to discuss these concerns, but also to introduce you to our coalition's broader interests in FHA's increasingly important healthcare programs. Please feel free to contact Senior Associate Director from the American Hospital Association, Michael Rock at 202-626-2325 or counsel to the Committee of Health Care Financing, Michael Mazer, at 202-293-8227 if you have any questions.

Thank you for your consideration. We look forward to working with you and OIHCF on these very important FHA healthcare initiatives.

AMERICAN HOSPITAL ASSOCIATION



Rick Pollack
Executive Vice President