30-Day Planning Document
Office of Insured Health Care Facilities (OIHCF)

What the office does:

OIHCF operates the Section 242 program, Mortgage Insurance for Hospitals. Section 242 enables the affordable financing of needed hospitals by reducing their cost of capital. The program improves access to quality health care, reduces the cost of hospital care, supports HUD's community development mission, and contributes revenues to the General Insurance Fund.

How the office operates:

Due to the highly specialized nature of hospital financing, management and operation of the Section 242 program are centralized in Headquarters. Thus, OIHCF performs program management functions typical of Headquarters offices as well as day-to-day program operations typical of field offices. The Multifamily Hubs provide very limited support in certain areas, the most significant being environmental reviews. Under a Memorandum of Agreement, the U. S. Department of Health and Human Services (HHS) supports the program with about 30 staff in the areas of underwriting, loan monitoring, and architectural/engineering services.[1] HUD and HHS strive to operate as one virtual organization, although the involvement of two agencies inevitably creates some inefficiencies. HUD is solely responsible for program policy, approval of new loans, and all significant asset management decisions.

The functions of the office may be grouped into the following categories:

1. **Program management** - policies, procedures, regulations, handbooks, interaction with other parts of HUD, resource management.

2. **Loan origination** - managing the application pipeline, conducting preliminary reviews of hospitals proposed for Section 242 financing, representing the program to lenders, reviewing projects after a complete application is filed, and making recommendations for approval or denial to the Commissioner.

3. **Asset management**, comprised of the following subfunctions:
   - **Loan management** - reviewing and approving or denying requests from hospitals in the portfolio to take actions that require HUD approval under the Regulatory Agreement and loan covenants.
   - **Loan monitoring** - surveillance of hospitals with insured loans and identification of hospitals with declining financial performance that could pose a risk of default.

[1] Within the Health Resources and Services Administration, the Division of Facilities and Loans, located in Rockville, MD, provides approximately 18 FTE for underwriting and loan management support. Five of these are outstationed in New York City. The Division of Engineering Services in New York City provides approximately 12 FTE, several of which are outstationed in Fort Worth and Seattle.

- **Interventions** - helping individual hospitals avoid default by employing a variety of proactive measures such as refinancings, providing consultants, communicating with the governing board, authorizing release of reserve funds, approving mergers and affiliations, etc.
- **Bankruptcy management** - when a portfolio hospital seeks bankruptcy protection, working closely with all parties to protect HUD's security interests and avoid a loan default.
- **Post-insurance activities** - when a loan is assigned to HUD as a result of default, intervening to help the hospital improve its financial condition, entering into workouts, and marketing and arranging the sale of the loan (currently there are no HUD-held hospital loans).

4. **Administrative support** - managing consultant contracts, maintaining the program information system, and performing routine administrative functions.

Strategic Vision:

- Diversify the portfolio geographically to reduce risk and serve more communities
- Improve the portfolio's overall credit quality
- Through careful underwriting and loan monitoring, pay no claims
- Provide outstanding customer service to keep good credits in the portfolio
- Maintain strategic capacity including appropriate resources, skills, and products

How strategic vision supports Housing and HUD goals:

Goal: Strengthen communities. Modern hospitals are a critical part of communities' infrastructure. Section 242 mortgage insurance enables hospitals to access affordable capital for needed construction and modernization projects. Also, hospitals are usually among the largest employers in their communities, providing jobs across the economic spectrum.

Goal: Promote participation of faith-based and community organizations. A high percentage of Section 242 loans go to hospitals operated by faith-based organizations. Most of the remainder of the portfolio consists of hospitals operated by not-for-profit community-based organizations.

Goal: Embrace high standard of ethics, management, and accountability. OIHCF's vision of geographic diversification, improving the portfolio's credit quality, and paying no claims supports this goal. The aim is to continue Section 242's record of financial soundness that has made affordable capital available for 336 hospital projects totaling $11.2 billion at no cost to the taxpayer.

How the strategic vision changes the business we do/the way we do business:

The strategic vision does not fundamentally change the nature of our business. However, because the office has been successful in pursuing its vision with respect to geographic diversification and customer service, the volume of business has increased dramatically. Instead of the historical level of 3-4 insurance commitments per year, in FY 2004 there were 12 projects approved (totaling $1.34 billion) and there are now 21 projects in the application pipeline, with two less staff members than last year.

OIHCF is continually evaluating and improving the way it does business to increase efficiency while maintaining program financial standards. For example, it has contracted out some work previously performed in house. Also, two years ago it redesigned the application intake process to avoid wasting staff time on applications with a low probability of approval. Despite improvements such as these, the staffing level has not kept up with the pace of business. Geographic diversification outside of New York State, where the bulk of the portfolio has been historically, requires OIHCF to develop expertise in other regions, and that requires resources. See **Exhibit 1, Management Challenges in 2005**, attached, and "**What the strategic vision means we will require**" below.

What we have now - staff, FTE, skill sets:

- 11 staff members in OIHCF
- Slightly more than 11 FTE due to overtime and use of two part-time Special Government Employees
- Skills include hospital management (for profit and not-for-profit), management of multi-hospital systems, hospital financial analysis and accounting (CPA), knowledge of HUD, consulting, writing, negotiating, bond financing, and general management.

What the strategic vision means we will require - staff, FTE, skill sets:

1. ***OIHCF will need additional staff members with the skills listed above and other skills discussed in the next section below.*** Although HHS and contractors provide vital support, in-house staff members are needed to meet the policy challenges posed by (1) geographic diversification (every state is different), (2) demand from rural hospitals (the program historically served mostly urban hospitals), (3) new refinancing methods being introduced by investment banks, and (4) hospitals requiring HUD's intervention to avoid default.

2. We must also retain highly qualified staff members. OIHCF staff at the GS-13 and 14 levels, with extensive experience as hospital CEO and CFO, could command much higher salaries if they returned to the private sector. Their skills are in demand by hospitals and mortgage/investment banks. *We must be able to offer promotions or we risk losing staff members with the rare combination of hospital industry and Section 242 program skills.*

3. *Improving the HUD-HHS Relationship*. In 1992, Deputy Secretary Dellibovi commissioned a study of the organizational structure of the Section 242 program. He was concerned that the split of duties between HUD and HHS might be causing inefficiencies and weaknesses in internal controls. The report, prepared by the Office of Management and Planning, documented poor client service and weaknesses in loan monitoring. It concluded that the public would be better served, and HUD's insurance risks reduced, if the program were consolidated within HUD. However, the incoming administration had other priorities and no action was taken as a result of the report. In 1996, the General Accounting Office (GAO) released a report on Section 242 that focused principally on the risks of geographic concentration of the portfolio in New York State; however, the GAO reviewers were also concerned that the split of duties between HUD and HHS could weaken program execution. Today, the GAO is again reviewing the program, focusing specifically on the HUD-HHS relationship as required by the Congress (**Exhibit 2**).

   In 1997-98, HUD and HHS program staff, aided by consultants, underwent a Business Process Reengineering project that reduced layers of review in each agency, created joint HUD-HHS project teams and a joint credit committee, and streamlined the loan application and loan modification processes. That reengineering helped HUD and HHS program staff to manage the program in a more coordinated way and to improve client service.

   As stated above, HUD and HHS strive to operate as one "virtual staff." However, physical separation, differences in culture and attitude, and communications difficulties create a constant challenge, draining energy and time and sometimes confusing and frustrating client bankers and hospitals.

   Consolidating program administration within HUD (with HHS personnel becoming HUD employees) would solve these problems, but that is a major undertaking requiring Congressional involvement. However, there is a measure that would go a long way toward solving the problem and could be accomplished administratively. That would be to co-locate at HUD the core HHS operation, consisting of 13 underwriting and loan monitoring managers and staff devoted to the HUD program who are currently stationed in Rockville, MD. Putting all of the Washington-based program staff in the same office would result in a tremendous improvement in the use of resources. It would eliminate duplication of effort, client confusion, "shopping for answers" by bankers and hospitals seeking favorable determinations from HUD or HHS, impediments to communication, and differences in approach due to different cultures and attitudes.[2]

[2] There would still be five employees outstationed in New York providing underwriting and loan management support, reporting to the head of the Division of Facilities and Loans, whose new duty station would be at HUD. The Division of Engineering Services would not be affected, but that is not where most of the coordination problems occur.

This change could be accomplished under the upcoming revision to the agreement between the agencies. We would have to find contiguous office space in HUD for the HHS staff. (HUD would save money by not having to pay HHS for office space for these employees as it does under the current Memorandum of Agreement.)

Please note that this idea has NOT been discussed with HHS.

4. *Improving Contracting Processes*. Achievement of the vision to "maintain strategic capacity including appropriate resources, skills, and products" has been hampered by HUD contracting policies and procedures that are beyond the control of this office. OIHCF relies on contracted consultants to help it review the feasibility of proposed projects and deal with financially troubled hospitals. It also depends on contracted computer programmers to keep the automated information system[3] running and compatible with changing business needs. Work orders for consultant services are often delayed, impairing our ability to achieve the vision to "provide outstanding customer service" and to "pay no claims." The work orders seem to disappear once they leave Housing and resurface only after extensive inquiries as to their status. The information system is an essential part of loan monitoring, yet the process of getting a contract in place to maintain and modify the system has dragged on for almost two years; if the system crashes today, there is no one to fix it. .

Note: In other Departments, there are contracting officers within the program offices who are responsive to the needs of management. This is the case in HHS, where the Division of Engineering Services, with its own contracting officer, has been able to procure specialized consulting services within a few weeks when needed in support of the review of proposed Section 242 projects. At HUD, similar contracts would have taken a year or more to obtain - too late to do any good for the project at hand. With an over-abundance of caution, HUD has concentrated all contract authority in the office of the Chief Procurement Officer, apparently due to irregularities in the past. That office is not capable of meeting the needs of its client, the Office of Housing. OIHCF recommends that the Office of Housing elevate this issue with the aim of obtaining quality, timely, and correct contract services. One option would be for this small Department, HUD, to outsource its contracting to a larger agency, for example, the Department of Defense, where resources and expertise are available. A precedent is the outsourcing of payroll functions, formerly performed within HUD, to the Department of Agriculture.

[3] Hospital Mortgage Insurance Management Information System (System # P046), a web-based information system containing loan, financial, operational, transactional, correspondence, reserve fund, and other data pertaining to each hospital in the insured portfolio and application pipeline. The system is used by HUD and HHS staff.

Gaps between what we have and what we will need:

The immediate need is to:

- *Fill the Portfolio Management Officer (division head) job that was vacated last July and*
- *Add at least one financial analyst (CPA) to the staff.*

Both should have extensive knowledge and experience in hospital finance.

Within two years, as the portfolio grows, we anticipate that we will need additional resources with specific skills:

- An individual with extensive skills gained in performing HUD asset management duties, including experience in refinancings, bankruptcies, claims and assignments, workouts, foreclosures, and property sales. The one employee with knowledge and experience in these areas was recruited and hired by an investment bank last year. This individual would work for the Portfolio Management Officer.
- An individual with experience in hospital financing who can assume duties from the current Operations Officer position, including management of the pipeline and the application process. The span of responsibilities of the current position is too broad; it includes not only those duties but also program policy and procedure, contract management, information systems management, quality control of underwriting reports and other written products, and more. In a small office, much of this work is "hands on" and time consuming, and another staff member is required to cover everything adequately.
- As a part-time or contract resource, a physician with senior experience on the medical staff of hospitals. A retired Chief Medical Officer or a consultant specializing in this field would be ideal. Frequently, OIHCF has found that one of the reasons a hospital gets into financial trouble is poor relations, or simply poor communications, between management and the medical staff. The right physician consulting for HUD could help management and the medical staff to appreciate each other's needs and devise solutions to improve both quality of care and hospital financial performance. This resource would be deployed as needed to help hospitals posing a threat of default on their FHA-insured loans.

Positions identified for buyout authority, and justification:

None.

Exhibit 1
MANAGEMENT CHALLENGES IN 2005

Today, the Office of Insured Health Care Facilities (OIHCF) has three principal management challenges. The first is to respond to a continuing surge in the industry's demand for our product. The second is to continue to manage our assets in a way that protects the taxpayers and respects the needs of communities with FHA-insured hospitals. The third is to maintain and effectively manage a level of resources that will enable OIHCF to meet the first two challenges successfully.

Surge in Demand

Interest in FHA-insured financing for hospitals is at an all-time high, for several reasons. The first is that in the late 90's HUD made improvements in its administration of the Section 242 program, resulting in a process that reduces time, expense, and red tape for clients. The second is that a general downgrading of the credit ratings of hospitals occurred in recent years. Financially sound hospitals that could have obtained private bond insurance for capital projects several years ago cannot do so today, so they are exploring the FHA option. A third reason is that the Hospital Mortgage Insurance Act of 2003 removed impediments to participation by hospitals in the 24 states without Certificate of Need programs for hospitals. The fourth reason is that the Congress has enacted special Medicare reimbursement provisions to assist rural hospitals. Some of these hospitals are now financially able to enter the capital markets to renovate or replace aging facilities, but the small size of their projects does not interest private insurers, so many are turning to FHA.

As a result of these developments, there is a high level of inquiries about Section 242 financing and the application pipeline has grown. FY 2004 broke records, with 12 projects approved for $1.34 billion. Currently, there are 21 projects in the application pipeline with applications totaling $891 million. For most previous years, new Section 242 loans have numbered three or four per year. The increased workload has challenged our resources at HUD and HHS.

Asset Management.

The Balanced Budget Act (BBA) of 1997, combined with the growth in HMOs (managed care) resulted in cuts in the reimbursement levels of hospitals nationwide. These cuts began to affect hospitals' finances negatively in 1998-99 and continue to do so today. Reductions in Medicaid reimbursement levels in some states in the past two years have created additional challenges for hospitals. In New York State, with the bulk of the HUD portfolio, deregulation further contributed to the financial challenges faced by FHA-insured hospitals. Many hospital managers have been able to adapt to these changes, but some have not. This situation has required close monitoring and, in some cases, active intervention by HUD to help financially troubled hospitals remain solvent and able to make payments on their insured mortgages. There are several financially marginal hospitals in our portfolio that could default on their mortgage payments and require HUD to pay insurance claims. The

recently passed New York State budget, however, provides some financial relief. Even so, a high level of alertness and engagement must continue.

Resources

For OIHCF to be successful in meeting the challenges of managing assets and processing new loans, it must accomplish the following resource actions:

- Hiring. Filling the Portfolio Management Officer job that was vacated last July and getting another financial analyst on staff are critical to help OIHCF deal with the financially troubled hospitals in the portfolio and avoid large insurance claims.

- Managing the HHS relationship. Because HUD's agents in HHS are in a different agency with a different culture and priorities, OIHCF must pay continuous attention to keeping all of its program representatives coordinated and consistent. Activities that help accomplish this include project teams containing both HUD and HHS members, the weekly Program Management Group (PMG) meetings of senior HUD and HHS staff members, a shared information system, and regular informal communications.

- New Interagency Agreement. A major procurement action this year is an interagency agreement with the Department of Health and Human Services for continuation of the services they provide to the Section 242 program. Since 1968, HHS has supported HUD in administering the program. HHS assists with underwriting, loan management and monitoring, and architectural/engineering services. Approximately 30 FTE at HHS are dedicated to the HUD program, and HUD reimburses HHS for their salaries and expenses. The interagency agreement must be in place by September 30, when the previous agreement expires.

- New consulting contract. On September 30, the Office of Procurement and Contracts awarded a new contract to a small business. The contractor has started to perform independent feasibility reviews and to help selected hospitals improve their financial performance. Since the contract is new, OIHCF is spending considerable time with the contractor's people until they learn what we expect of them.

- New system contract. OIHCF must put in place a new multi-year contract for maintenance and development in support of the Hospital Mortgage Insurance Management Information System. OIHCF was not permitted to continue with the vendor that built the system and maintained it for several years. The required change of vendors has resulted in significant increases in the cost of development and maintenance for HMIMIS, threatening the ability to make critical improvements. *The original statement of work was submitted to the Chief Information Officer's staff in June of 2003 and the contract has yet to be awarded.*

- New Regulation. A valuable resource for successful management of the program is clear, well-organized program guidance. This office is revising a new regulation for the program following receipt of some 70 pages of public comment. It is a complete rewrite of the 1996 regulation. Following the regulation, the program handbook must be updated. Additionally, internal procedural and policy guidance for HUD and HHS staff must be updated. This is especially important today, since HUD is dealing with many bankers who are inexperienced in the program. It is also important because unclear or conflicting guidance can increase insurance risks and leave OIHCF vulnerable to criticism from clients and outside auditors.