INSURING FAILURE: ASSESSING WHO BENEFITS FROM FEDERAL NURSING HOME MORTGAGE GUARANTEES

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For over sixty years, the U.S. Department of Housing and Urban Development (HUD) has insured loans to nursing homes with the aim of supporting infrastructure improvements that can promote quality of care, especially for marginalized populations. Yet although HUD's mortgage insurance program (termed "Section 232" in reference to the portion of the code of federal regulations in which it appears) has been in continual operation since 1959 and represents a substantial public investment, there has been little research on its impact. This Essay fills that gap by providing the first systematic analysis of the extent to which Section 232's subsidies reach nursing homes with the greatest financial need and whether the program drives improvements in quality of care. Concerningly, we find that as a whole, Section 232 neither supports those homes most in need of capital nor drives improvements in quality of care at nursing homes. Rather, we find that Section 232 serves primarily as a refinancing tool for larger for-profit facilities and is underutilized by facilities serving vulnerable populations, with loans primarily going to facilities that disproportionately serve Medicare-covered residents in census tracts that are more white. In fact, not only do we find no evidence of improved quality in nursing homes that receive Section 232 loans, we find that such receipt is associated with practices that correlate with lower quality of care, including reduced nursing staff time. We conclude by considering the implications of these findings for federal long-term care policy, and propose specific reforms to better align Section 232's operational approach with its underlying objective of expanding marginalized populations' access to quality long-term care.

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INTRODUCTION 205
I. SECTION 232'S DESIGN, OBJECTIVES, AND COST 209
II. EMPIRICAL STUDY 213
A. Study Design 213
B. Findings 217
1. Types of Loans 218
2. Factors Associated with Receiving 223(f) Loans.....220
C. Study Limitations 225
III. ASSESSING SECTION 232'S EFFICACY IN LIGHT OF STUDY FINDINGS 226
A. Does Section 232 Support Marginalized Communities? 226
B. Does Section 232 Support Homes in Need of Capital? 228
C. Does Section 232 Improve Nursing Home Quality?.....229
IV. REFORMING SECTION 232 TO EXPAND ACCESS AND PROMOTE QUALITY 231
CONCLUSION 236
ADDITIONAL EXHIBITS 237

INTRODUCTION

Recent years have witnessed increased attention to the plight of the approximately 1.2 million Americans who reside in nursing homes in the United States.[1] In the wake of the COVID-19 pandemic, which began with unprecedented death rates in the nation's nursing homes, policymakers focused on the problems associated with facility mismanagement, including chronic understaffing.[2] But while debates about staffing levels raged on Capitol Hill, another factor affecting quality of care in American nursing homes received far less attention: the facilities themselves.[3]

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[1] Priya Chidambaram & Alice Burns, *A Look at Nursing Facility Characteristics in 2025*, KFF (Dec. 17, 2025), https://www.kff.org/medicaid/a-look-at-nursing-facility-characteristics [https://perma.cc/5VEP-24F4] (reporting that there were 14,742 certified nursing facilities with 1.2 million residents in the United States in 2025).

[2] *See* Nina A. Kohn, Adrianna Duggan, Justin Cole & Nada Aljassar, *Using What We Have: How Existing Legal Authorities Can Help Fix America's Nursing Home Crisis*, 65 WM. & MARY L. REV. 127, 130, 134–39 (2023) (discussing the effect of staffing on quality of care).

[3] Indeed, the most significant reform in the nursing home space after the COVID-19 pandemic was the creation of a long-awaited minimum staffing standard for nursing homes, rolled out by the Centers for Medicare & Medicaid Services in the final months of the Biden Administration. Press Release, Ctrs. for Medicare & Medicaid Servs., Biden-Harris Administration Takes Historic Action to Increase Access to Quality Care, and Support to Families and Care Workers (Apr. 22, 2024), https://www.cms.gov/newsroom/press-releases/biden-harris-administration-takes-historic-action-increase-access-quality-care-and-support-families [https://perma.cc/HA56-EV97]. That regulation met firm opposition from the nursing home industry and was ultimately repealed by the Trump Administration in December 2025. Press Release, U.S. Dep't of Health & Hum. Servs., HHS' Cleanup of Federal Nursing Home Minimum Staffing Standards Rule Expands Access to Rural and

At present, nursing homes in the United States frequently operate in aging facilities that not only create an unpleasant and "institutional" environment, but also impede infection control protocols and other best practices.[4] Yet nursing homes typically operate on narrow financial margins, making it difficult to simultaneously invest in infrastructure improvements and the staff and direct care support needed to deliver high-quality care.[5]

For more than six decades, the Department of Housing and Urban Development (HUD) has operated a program that might address these financial barriers: the Mortgage Insurance Program for Nursing Homes, Intermediate Care Facilities, Board and Care Homes, and Assisted Living Facilities (more commonly called Section 232 in reference to the section of the federal code creating it).[6] Established in 1959, the program was created "to help reduce the national shortage of nursing homes by providing facilities that are economically sound and structurally adequate for the safety and proper care of occupants."[7] Fundamentally, Section 232 reduces lender risk

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Tribal Health Care (Dec. 2, 2025), https://www.hhs.gov/press-room/hhs-cleanup-federal-nursing-home-minimum-staffing-standards-rule-expands-access-rural-tribal-health-care.html [https://perma.cc/6DL9-YUUM]; *see* Press Release, Am. Health Care Ass'n, Nursing Homes React to Staffing Mandate Final Rule (Apr. 22, 2024), https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/Nursing-Homes-React-to-Staffing-Mandate-Final-Rule.aspx [https://perma.cc/ZNJ2-ECK2] (opposing minimum staffing standard); Press Release, Stacey Hughes, Exec. Vice President, Am. Hosp. Ass'n, AHA Statement on Final Rule on Minimum Staffing in Nursing Homes (Apr. 22, 2024), https://www.aha.org/press-releases/2024-04-22-aha-statement-final-rule-minimum-staffing-nursing-homes [https://perma.cc/CK8S-8N5A] (same).

4 As the National Academies of Sciences, Engineering, and Medicine have found: "Although the nursing home's physical environment is critical to residents' quality of life, the nursing home infrastructure is aging, and most nursing homes resemble institutions more than homes. Smaller, home-like environments play key roles in infection control and enhancing the quality of life for residents as well as staff." NAT'L ACADS. OF SCIS., ENG'G & MED., THE NATIONAL IMPERATIVE TO IMPROVE NURSING HOME QUALITY: HONORING OUR COMMITMENT TO RESIDENTS, FAMILIES, AND STAFF 7 (2022).

5 *See* AM. HEALTH CARE ASS'N, STATE OF THE NURSING HOME SECTOR 19 (2024), https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/AHCA%20State%20of%20the%20Sector%202024.pdf [https://perma.cc/R6A2-A5NR] ("87% of nursing homes are on the brink: either operating in the red or barely breaking even."); Rachel M. Werner, Allison K. Hoffman & Norma B. Coe, *Long-Term Care Policy After COVID-19—Solving the Nursing Home Crisis*, 383 NEW ENG. J. MED. 903, 903 (2020) (describing nursing homes as "poorly funded").

6 24 C.F.R. pt. 232 (2026); *see* FED. HOUS. ADMIN., ANNUAL MANAGEMENT REPORT 70 (2023) ("Healthcare programs ([including] Section 232 . . .) enable low cost financing of healthcare facility projects and improve access to quality healthcare by reducing the cost of capital.").

7 SUBCOMM. ON ECON. PROGRESS OF THE JOINT ECON. COMM., 89TH CONG., REPORT ON FEDERAL PROGRAMS FOR THE DEVELOPMENT OF HUMAN RESOURCES 1058 (Comm. Print 1966); *see also* U.S. GOV'T ACCOUNTABILITY OFF., GAO-06-515, RESIDENTIAL CARE FACILITIES MORTGAGE INSURANCE PROGRAM: OPPORTUNITIES TO IMPROVE PROGRAM AND RISK MANAGEMENT 7 (2006) ("According to HUD officials, in recent times, the Section 232 program exists, in part, to support the market for residential care facilities when the private market is reluctant to finance such projects due to market conditions.").

and enables borrowers to secure loans at lower interest rates by insuring mortgages made by private lenders.[8]

Section 232 represents a substantial public investment. By late 2024, Section 232 managed over 3,600 loans with an unpaid principal balance of more than $32 billion.[9] And in 2025, the program issued a "record-breaking $8.1 billion in firm commitments" for residential care facilities—nearly double the amount it had issued just one year earlier.[10] With the program's growth accelerating in recent years, so too do the program's potential losses as HUD—and thus taxpayers—are ultimately responsible if a facility is unable to pay the insured mortgage.[11]

Yet it is unclear whether this investment is furthering the federal government's broader goals for nursing homes, such as expanding access to nursing homes for vulnerable Americans or promoting high-quality nursing home care.[12] Indeed, there is no research to date on the communities served by Section 232 or whether receipt of Section 232 loans is associated with improvements in quality of care. These questions are crucial. The COVID-19 pandemic brought to light substantial quality-of-care problems in nursing homes, and research suggests that further declines in quality of care are occurring due to the growing involvement of private equity firms and other investment entities in the nursing home market.[13]

Additionally, emerging evidence suggests that Section 232 may

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[8] *See Healthcare Programs: Office of Residential Care Facilities (Section 232)*, U.S. DEP'T OF HOUS. & URB. DEV., https://www.hud.gov/hud-partners/healthcare-programs#section232 [https://perma.cc/DT9B-2WL7] (last visited June 15, 2026) ("The benefit to the borrower is that the loan is at a fixed interest rate, often lower than conventional rates . . . .").

[9] *HUD's Oversight of Section 232 Nursing Home Portfolios*, U.S. DEP'T OF HOUS. & URB. DEV. OFF. OF INSPECTOR GEN., https://www.hudoig.gov/library/ongoing-work/huds-oversight-section-232-nursing-home-portfolios?utm [https://perma.cc/C9Z3-MDKD] (last visited June 15, 2026).

[10] Kathleen Steele Gaivin, *FHA Closes 'Landmark Year' with $8.1B in Firm Commitments, $6B in Mortgages in Senior Living and Care*, MCKNIGHT'S SENIOR LIVING (Jan. 23, 2026), https://www.mcknightsseniorliving.com/news/fha-closes-landmark-year-with-8-1b-in-firm-commitments-6b-in-mortgages-in-senior-living-and-care [https://perma.cc/VLL7-CF3S].

[11] *See id.*; Kohn et al., *supra* note 2, at 181 (observing that "applications for Section 232 loans have increased significantly in recent years").

[12] *Cf.* U.S. GEN. ACCT. OFF., GAO/RCED-95-214, GREATER OVERSIGHT NEEDED OF FHA'S NURSING HOME INSURANCE PROGRAM 16 (1995) (faulting HUD on the grounds that it had "not collected and analyzed information needed for it to effectively manage the nursing home program and for it to assess whether the program's benefits outweigh its costs").

[13] *See* Ashvin Gandhi, YoungJun Song & Prabhava Upadrashta, *Private Equity, Consumers, and Competition: Evidence from the Nursing Home Industry* 8 (Nat'l Bureau of Econ. Rsch., Working Paper No. 34306, 2026) ("Private equity acquisitions in the healthcare industry have grown more prevalent and consequential in recent decades."); Gregory N. Orewa, Aizhan Karabukayeva, Rohit Pradhan, Itopa Jimoh & Robert Weech-Maldonado, *The Effects of Private Equity Ownership in U.S. Nursing Homes Quality and Financial Performance: A Systematic Review*, 161 HEALTH POL'Y 1, 9 (2025) ("[T]he overarching consensus suggests that PE ownership introduces pressures that can compromise comprehensive care quality.").

disproportionately support facilities that arguably least warrant such assistance. A 2023 study by two of this Essay's authors found that nursing homes that receive HUD-backed mortgage insurance tend to rank at or below average in quality of care when measured by overall rating, nursing staffing hours per resident per day, and health citations.[14] And a 2025 study found that the majority of Section 232 loans are obtained by for-profit facilities, facilities located in counties with a higher concentration of nursing homes, and facilities with stronger operating margins.[15] These findings raise concerns about whether the program is effectively targeting the most vulnerable nursing homes.

We thus undertook a study to examine three key questions that would allow us to assess Section 232 against its purpose, both as it was originally envisioned and as it has come to be regarded. First, how are Section 232 loans used? Second, which types of facilities benefit from such loans? Finally, how do nursing home characteristics change in the period following the receipt of a loan through Section 232? To answer these questions, we used three large datasets to examine Section 232-backed loan trends over time and identified facility- and market-level factors associated with insurance uptake. We then analyzed whether Section 232 loans were associated with changes in indicators of nursing home quality. Finally, by matching loan information with census tract data, we were able to identify the demographic characteristics of the communities in which facilities with Section 232 loans are located and compare those communities with ones whose nursing homes did not receive such loans.

This Essay conveys the results of that study and considers its implications, proceeding in four parts. In Part I, we discuss the design and objectives of Section 232. In Parts II and III, we explain our study design and present and discuss our key findings. We explain that our study indicates that Section 232 serves primarily as a refinancing tool rather than a mechanism for supporting new developments or improvements in quality of care. We also demonstrate that Section 232 is disproportionately used by homes that serve Medicare-covered residents in census tracts with higher levels of white residents. In addition, we find little evidence that receipt of a Section 232 loan corresponds with improvements in quality of care and indeed find that it is actually associated with factors correlated with worse quality of care. Finally, in Part IV, we outline ways to reform Section 232 to

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14 Kohn et al., *supra* note 2, at 185–86.

15 Robert Tyler Braun, David Rosenkranz, Rahul Fernandez, David G. Stevenson, David C. Grabowski, Dunc Williams, Luz Jimenez & John Bowblis, *Assessing Facility, Resident, and Financial Characteristics Associated with HUD 232-Sponsored Loan Participation in Nursing Homes*, 26 J. AM. MED. DIRS. ASS'N 1, 4–5 (2025); *see also* Kohn et al., *supra* note 2, at 184 (noting that 94.9% of nursing homes that received Section 232 loans in fiscal years 2020 and 2021 were for-profit nursing homes).

better align the program with the federal government's broader policy goals around long-term care.

I
SECTION 232'S DESIGN, OBJECTIVES, AND COST

Congress originally established Section 232 in 1959 to encourage the construction of nursing homes.[16] At the time, the Medicaid program—which now pays the costs of roughly 60% of nursing home residents—had yet to be established.[17] The resulting lack of a "reliable income stream" for nursing homes led to a concern that for-profit entities would have difficulty obtaining the financing needed to construct new facilities.[18] Drawing on the Federal Housing Administration's experience in credit enhancement programs, Section 232 was originally designed to encourage lenders to make capital available to for-profit nursing homes by minimizing the risk of losses.[19] Five years later, the program was expanded to nonprofit nursing homes.[20]

Section 232 has been described as especially "critical to the capital access [of nursing homes] . . . located in economically distressed areas with high charity-care burdens."[21] In a statement before a Senate hearing in 1985, the Healthcare Financing Study Group, an association of national investment bankers and underwriters who participated in the financing, construction, and rehabilitation of nursing homes, described the healthcare facilities which most commonly used Section 232 as being "located in rural or inner-city areas, serving the elderly, working poor, and others who typically lack private access to quality medical care."[22] The Group argued that the aging of the population and changes in family systems—such as more women working outside the home—would lead to a growth in demand for nursing home care that would outstrip the supply provided by the private market.[23] Key to this argument was a claim that Section 232 typically subsidized homes serving particularly challenging, vulnerable, and less profitable

16 U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 7, at 7.

17 *Distribution of Certified Nursing Facility Residents by Primary Payer Source, 2025*, KAISER FAM. FOUND., https://www.kff.org/state-health-policy-data/state-indicator/distribution-of-certified-nursing-facilities-by-primary-payer-source/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/ABJ3-KN73] (last visited June 16, 2026).

18 U.S. GEN. ACCT. OFF., *supra* note 12, at 4–5.

19 *Id.* at 5.

20 *Id.* at 4 n.7.

21 *Housing, Community Development, and Mass Transportation Authorizations—1986*: *Hearings Before the Subcomm. on Hous. & Urb. Affs. of the S. Comm. on Banking, Hous., & Urb. Affs.*, 99th Cong. 1100 (1985) (statement of the Healthcare Fin. Study Grp.).

22 *Id.* at 1095.

23 *Id.* at 1097.

populations. Specifically, the Group asserted that:

> [T]he projects which typically rely on Section[] 232 . . . are located in rural and inner-city areas, with patient loads heavily composed of Medicare, Medicaid, and low-income free-care patients. *The nature of these facilities' patient loads prevents them from obtaining investment-grade credit ratings.* The credit enhancement provided by the Section 232 . . . program[] enables these facilities to receive investment-grade ratings and, therefore, has made capital available at considerably lower rates than would otherwise be the case. *Indeed, absent such credit enhancement, the only financing alternatives for these facilities are the usurious rates in the "junk bond" market or simply not undertaking capital projects at all.*[24]

Around the same time, members of Congress similarly characterized Section 232 as a means of supporting facilities located in geographic areas with heightened resource needs.[25] For example, Representative Robert Garcia (D-NY) urged Congress to reauthorize and expand Section 232 because projects that applied for the program were typically "those that cannot obtain affordable credit on their own," such as "facilities in inner cities and rural areas that serve low-income and elderly populations."[26]

In more recent years, federal officials have also suggested that the program is a means of improving quality of care.[27] In June 2025, for example, the Federal Housing Administration announced an "Express Lane" program for Section 232, permitting applicants to have queue priority if they satisfied certain criteria, including various attributes related to quality of care (e.g., a minimum of a two-star weighted health inspection score and overall rating by the Centers for Medicare & Medicaid Services (CMS)).[28]

Whether Section 232 is a way to increase capital access for nursing homes, especially in economically distressed areas, or improve quality of care, it functions by helping facilities obtain more favorable loan terms. The program does so in several ways. First, HUD-insured loans tend to have lower fixed interest rates and can be leveraged to a greater extent than is typical for conventional loans—with loan-to-value ratios of up to 90% of

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24 *Id.* at 1099–100 (emphasis added).

25 *See* 132 CONG. REC. 12332 (1986) (statement of Rep. Robert Garcia).

26 *Id.*

27 *See, e.g.*, *LEAN 232 Email Blasts*, U.S. DEP'T OF HOUS. & URB. DEV. (May 9, 2022), https://www.hud.gov/hud-partners/healthcare-programs-orcf-lean232 [https://perma.cc/NKV8-4W8G] (select "May" under "2022" in "Email Blasts by Date") ("An established successful track record of and commitment to quality of care in operations of the proposed facility type continue to be critical for successful participation in the Section 232 program.").

28 *LEAN 232 Email Blasts*, U.S. DEP'T OF HOUS. & URB. DEV. (June 11, 2025), https://www.hud.gov/hud-partners/healthcare-programs-orcf-lean232 [https://perma.cc/NKV8-4W8G] (select "June" under "2025" in "Email Blasts by Date"). As we explain further below, CMS Five-Star Quality Ratings assign each facility a score from one to five based on performance relative to peers. *See infra* note 57.

property value for nonprofit properties.[29] By contrast, interest rates for other loans are often based on the prime rate plus a margin, and loan-to-value ratios range from 70 to 80%.[30] Second, HUD-insured loans are available for a longer duration—up to thirty-five years as opposed to five to twenty-five years.[31] Finally, they are assumable by new owners and are primarily non-recourse, meaning lenders only have access to collateral in the event of default.[32]

To satisfy the eligibility requirements for Section 232, a nursing home must have at least twenty beds and be licensed and regulated by the state in which it is located.[33] The borrower, operator, or any of their affiliates cannot be in bankruptcy or have filed for bankruptcy in the previous five years,[34] and only borrowers, operators, and management agents whose principals have "at least three years of experience successfully operating multiple projects with the types of beds proposed will generally qualify for . . . mortgage insurance."[35] Those designated as Special Focus Facilities, a title reserved for the worst-performing nursing homes, also are ineligible.[36] Myriad other requirements and program features also apply to Section 232, many of which are related to state approvals, the implementation of internal programs, and disclosure.[37]

It is unclear how much the Section 232 program costs taxpayers. Its costs are not itemized in HUD budget requests to Congress, and HUD has not publicly shared complete data on how much it has lost as a result of mortgage defaults by facilities insured by Section 232.[38] There are, however, indications that losses are substantial. Relative to HUD's other commercial mortgage insurance programs for healthcare facilities, Section 232 has a high default rate. HUD data indicate that from October 2023 to October 2025, an

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29 *Underwriting Requirements for Nursing Home Properties*, FINANCELOBBY (Apr. 18, 2023), https://financelobby.com/cre-insights/underwriting-requirements-for-nursing-home-properties [https://perma.cc/673M-LCA7].

30 *Id.*

31 *Id.*

32 U.S. DEP'T OF HOUS. & URB. DEV., HEALTHCARE MORTGAGE INSURANCE PROGRAM HANDBOOK sec. II, ch. 2, § 2.5(P) (2017) [hereinafter SECTION 232 HANDBOOK]. The agency has circulated a revised draft of this handbook; feedback was due on March 7, 2025, but there is no indication that it has been finalized since then. U.S. DEP'T OF HOUS. & URB. DEV., HEALTHCARE MORTGAGE INSURANCE PROGRAM HANDBOOK (2025 draft), https://www.hud.gov/stat/sfh/draft-handbook?utm [https://perma.cc/2RJD-M7GF] [hereinafter 2025 DRAFT SECTION 232 HANDBOOK]. None of the proposed changes, which are redlined in the 2025 draft, meaningfully implicate this Essay's analysis.

33 SECTION 232 HANDBOOK, *supra* note 32, § 2.2(A)(1).

34 *Id.* § 2.3(C).

35 *Id.* § 2.5(FF).

36 *Id.* § 2.3(F).

37 *See generally id.* § 2.5 (outlining general Section 232 requirements).

38 HUD failed to respond to requests for more recent data on default rates or losses made pursuant to the Freedom of Information Act.

average of 2.8% of Section 232 loan recipients were in default in any given month.[39] Defaults peaked in June 2024, when 162 loans that HUD had made to residential care facilities were in default, with an unpaid balance of over $1.2 billion.[40] By comparison, between October 2023 and October 2025, the average monthly default rate for HUD-insured hospitals hovered around zero and the default rate for multi-family apartment facilities was 0.21%.[41]

While default rates are an indication of HUD's potential losses, not all defaults result in claims being made. Despite HUD's lack of transparency on losses, several reports provide insight into the potential scale of losses. For example, a 2018 report by the HUD Office of the Inspector General estimated that between 2011 and 2018, HUD incurred $32.1 million in losses on nursing homes that it sold after they had defaulted on their loans plus an additional $9.7 million from an insured nursing home that entered into bankruptcy proceedings.[42] Many years earlier, in 1994, HUD reported that the Section 232 program had incurred $187 million in losses.[43]

Taxpayers' exposure may even be increasing due to the risky business practices of insured facilities and overvaluation of insured properties. For example, in 2019, the Rosewood Care Centers chain of nursing homes collapsed, resulting in the chain defaulting on $146 million in HUD-insured loans.[44] The net cost to the government could not be offset by selling the homes: despite being insured for $146 million, the homes were actually worth "no more than $95 million."[45] A 2025 investigation into several New Jersey nursing homes suggests that such overvaluation may not be uncommon.[46] This history of financial losses, especially when combined

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39 *See* U.S. DEP'T OF HOUS. & URB. DEV., FHA COMMERCIAL MORTGAGE PORTFOLIO 13 tbl. 6 (Oct. 2025), https://www.hud.gov/sites/dfiles/Housing/documents/FHACommMortPortOctober2025.pdf [https://perma.cc/BR8Z-J2HH].

40 *Id.* at 14 fig. 6.

41 *Id.* at 8 tbl. 3 & 18 tbl. 9.

42 OFF. OF THE INSPECTOR GEN., U.S. DEP'T OF HOUS. & URB. DEV., HUD'S MONITORING OF THE FINANCIAL PERFORMANCE OF SECTION 232 NURSING HOMES, AUDIT REPORT NO. 2018-BO-0001, at 8 (2018), https://www.hudoig.gov/sites/default/files/documents/2018-BO-0001.pdf [https://perma.cc/FG5H-2WVG].

43 *See* U.S. GEN. ACCT. OFF., *supra* note 12, at 2. This report also revealed that HUD anticipated that 19% of its Section 232 portfolio (then totaling $3.7 billion) would result in losses.

44 *See* Matthew Goldstein, *$146 Million Default by Nursing Home Chain Leaves U.S. on the Hook*, N.Y. TIMES (May 31, 2019), https://www.nytimes.com/2019/05/31/business/nursing-homes-mortgage-hud.html [https://perma.cc/P25J-Z83Y] (noting that the cost to the federal government of such a default goes beyond $146 million, as the federal government had also spent more than $15 million to keep the nursing homes operational).

45 *Id.*

46 *See* N.J. OFF. OF THE STATE COMPTROLLER, AN INVESTIGATION OF FRAUD, WASTE, AND ABUSE IN TWO NEW JERSEY NURSING HOMES 29 (2025), https://www.nj.gov/comptroller/reports/2025/20251210.shtml [https://perma.cc/GE47-2TQX] (suggesting that overvaluation may stem from assessments that include not only the value of the real property of homes, but also their business operations).

with evidence of the federal government's growing exposure, underscores the need for systematic evaluation of Section 232's efficacy.

II
EMPIRICAL STUDY

We designed our study to evaluate: (1) recent trends in the utilization of Section 232 by identifying the types of loans insured under this program; (2) the facility- and community-level characteristics of the nursing homes that receive Section 232 loans; and (3) the correlation, if any, between the receipt of Section 232 loans and improvements in the quality of care provided to residents. Our study analyzed quarterly CMS nursing home data and HUD Section 232 loan allocations to nursing facilities spanning from the beginning of January 2016 through the end of September 2024.

A. Study Design

We relied on three publicly available datasets. First, we analyzed trends in Section 232 utilization by using loan-level data from HUD on Section 232 loans allotted from January 2016 to September 2024. These data detailed the loan type and amount, insurance date, bed count, and facility name for 1,759 loans across 1,741 nursing homes.[47] Second, we obtained quarterly facility-level data from CMS from January 2016 to September 2024.[48] The dataset included information on 16,624 unique nursing homes, including provider identifiers, ownership type (nonprofit, government, or for-profit), facility characteristics (e.g., bed count, number of residents), and performance metrics (e.g., nursing staffing hours per resident per day, weighted health inspection scores, facility-reported incidents, substantiated complaints, and number of fines).[49] Third, for census tract-level data, we relied on the 2022 American Community Survey (ACS) which averages data

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47 *Residential Care Facilities*, U.S. DEP'T OF HOUS. & URB. DEV., https://www.hud.gov/federal_housing_administration/healthcare_facilities/residential_care [https://perma.cc/K28Y-VL8M] (fiscal year end closing data between fiscal year 2016 and fiscal year 2024 within relevant dates in the section titled "Queues, Reports, and Statistics") (last visited June 8, 2026) (data on file with the N.Y.U. Law Review). It is worth observing that a small number of the nursing homes received more than one loan; some even received more than one 223(f) loan, a type of loan that is primarily for acquisition or refinancing. *See infra* notes 66–67 and accompanying text.

48 *Nursing Homes Including Rehab Services Archived Data Snapshots*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://data.cms.gov/provider-data/archived-data/nursing-homes [https://perma.cc/G3UL-MXRJ] (last visited June 8, 2026) (data on file with the N.Y.U. Law Review).

49 *See generally* CTRS. FOR MEDICARE & MEDICAID SERVS., NURSING HOME CARE COMPARE AND PROVIDER DATA CATALOG: CONSOLIDATED DATA DICTIONARY (2026), https://data.cms.gov/provider-data/sites/default/files/data_dictionaries/nursing_home/NH_Data_Dictionary.pdf [https://perma.cc/67K2-RDQD] (providing definitions for the various data metrics employed).

for five years spanning 2017 to 2021. These data were retrieved via the Census Bureau's Application Programming Interface using the tidycensus R package.[50] This time period largely overlapped with our study period. Census data were averaged across time periods and included total population as well as demographic characteristics such as racial composition, health insurance coverage, and median income.[51]

To link datasets, we used ArcGIS to identify the location of nursing homes in HUD and CMS data based on facility names. In ArcGIS, we then spatially joined the HUD and CMS data based on geographic proximity, matching each Section 232 loan to the closest CMS nursing home within a one-mile radius. We used nursing home addresses from CMS data to define latitude and longitude data, for which census data at the census tract level could be queried per facility. We manually validated each matched loan and nursing home pairing by comparing provider names and facility size across sources. Targeted verification using Google searches was performed when discrepancies arose, resulting in 568 corrected matchings and 19 HUD loans that were unable to be matched to a nursing home.

To understand factors associated with receiving Section 232 loans, we compared average census tract demographics from 2017 to 2021 (reflecting the most recent data available during the time period during which this analysis was performed) and nursing home characteristics in the loan year for facilities that received loans and those that did not. For this portion of the analysis, we focused exclusively on homes that received 223(f) loans.[52] These loans constituted the vast majority of Section 232 loans issued during the examined time period, and thus were the only type of loan that was sufficiently prevalent to enable a statistically significant analysis.[53] All of this yielded a final cohort of 1,502 223(f) loans provided to nursing homes by Section 232.[54] From 16,624 initial nursing homes, we excluded 230 facilities lacking CMS or census data and 229 nursing homes that received only loans that were not type 223(f). Our final dataset consisted of 16,165

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50 KYLE WALKER, MATT HERMAN & KRIS EBERWEIN, *tidycensus*, Ver. 1.8.1 (May 25, 2026), https://CRAN.R-project.org/package=tidycensus [https://perma.cc/W7KX-JGN6].

51 *See generally Census Data API User Guide*, U.S. CENSUS BUREAU (May 21, 2026), https://www2.census.gov/data/api-documentation/api-user-guide.pdf [https://perma.cc/6NP2-F5AA] (providing information on the Census API).

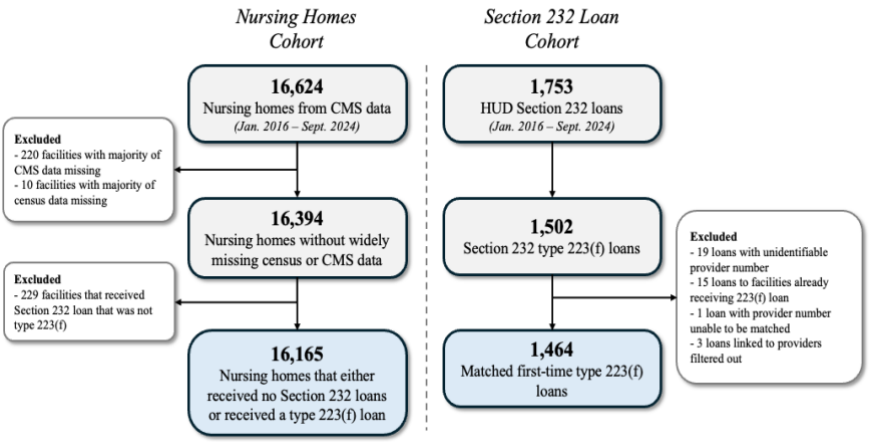
52 Section 223(f) loans are a type of Section 232 loan used for the acquisition and refinancing of facilities, as we describe in greater detail below. SECTION 232 HANDBOOK, *supra* note 32 § 2.9(A)–(B).

53 Indeed, during our analysis period from 2016 to 2024, 223(f) loans accounted for 85% of loans insured. *See infra* Table 1. It is worth noting as well that 223(f) loans can lead to other types of loans (e.g., 241(a)). *See Do HUD 232 Loans Allow for Supplemental Financing?*, JANOVER, https://www.hud232.loan/hud-232-faqs/supplemental-loan [https://perma.cc/UF9T-M8W7] (last visited June 24, 2026).

54 Additional details about our study methodology are included in our Supplemental Appendix (on file with the N.Y.U. Law Review).

nursing homes and 1,464 matched first-time type 223(f) loans. This process is visually depicted below in Figure 1.

FIGURE 1: FLOWCHART OF SELECTION PROCESS FOR NURSING HOMES AND SECTION 232 LOANS



Nursing home characteristics vary over time; accordingly, time-varying characteristics were extracted based on an index date for each facility. The index date for facilities receiving a type 223(f) loan was defined as the quarter preceding loan approval. Each non-recipient facility was assigned the index date of a matched nursing home with 223(f) uptake, with facility pairings made through propensity score matching.[55]

For each nursing home, we summarized facility characteristics[56] and performance characteristics—including CMS Five-Star Quality Ratings,[57]

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55 Propensity score matching is a statistical method used to create comparable groups by pairing units with similar characteristics based on their likelihood of receiving a treatment or exposure. *See generally* Paul R. Rosenbaum & Donald B. Rubin, *The Central Role of the Propensity Score in Observational Studies for Causal Effects*, 70 BIOMETRIKA 41 (1983) (describing propensity scoring and its utility); Peter C. Austin, *A Tutorial and Case Study in Propensity Score Analysis: An Application to Estimating the Effect of In-Hospital Smoking Cessation Counseling on Mortality*, 46 MULTIVARIATE BEHAV. RSCH. 119 (2011) (providing a tutorial on propensity score matching and discussing its utility). In our case, propensity score matching paired nursing homes that received loans with similar nursing homes that did not based on observable characteristics to create a comparable control group and align index loan years. We applied this technique to identify comparator dates for nursing homes without loans (control group) and match them—using bed count, state, and CMS Five-Star Quality Ratings as criteria—to those that had received Section 232 loans (intervention group). These matched controls were used in both descriptive and regression analyses to compare facilities with and without loans.

56 Facility characteristics include bed count; occupancy, calculated by dividing the number of residents by bed count; affiliation with a hospital; ownership type (for-profit, government, or nonprofit); and CMS certification status (Medicare, Medicaid, or both).

57 The CMS Five-Star Quality Ratings assign each facility a score from one to five based on

nursing staff capacity,[58] and CMS penalty variables[59]—using the four most recent fiscal quarters prior to the index date. The penalty variables—including incidents, substantiated complaints, and fines[60]—were coded as binary indicators, reflecting whether the facility received any such penalties prior to the index year.

We compared facilities with 223(f) uptake to those without any loan uptake. Differences in facility-level characteristics were assessed using Student's *t*-tests and chi-squared tests to identify statistically significant differences. We conducted multivariate logistic regression to estimate the odds of receiving a Section 232 loan.[61] For regression analysis, we log-transformed right-skewed variables, including bed count and median income, as well as the weighted health inspection score and nursing staffing

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performance relative to peers and consist of a staffing rating (based on nursing and staff metrics), survey rating (based on a weighted health inspection score), quality measure rating (based on resident health outcomes), and overall rating (derived from the other three ratings). *See* CTRS. FOR MEDICARE & MEDICAID SERVS., DESIGN FOR *CARE COMPARE* NURSING HOME FIVE-STAR QUALITY RATING SYSTEM: TECHNICAL USERS' GUIDE 3–4 (2026) [hereinafter DESIGN FOR *CARE COMPARE*], https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf [https://perma.cc/6EZ4-QXTK]; *Find & Compare Providers Near You*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.medicare.gov/care-compare [https://perma.cc/UB3F-2H8K] (last visited June 24, 2026); *see also Five-Star Quality Rating System*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS [https://perma.cc/C69L-MCHB] (last visited June 24, 2026) (providing a brief explanation of the rationale behind the CMS Five-Star Quality Rating System). While ratings in this system provide one indication of quality, we acknowledge that they do not fully capture quality. *See* Kohn et al., *supra* note 2, at 184 n.280 (providing sources discussing the limitations of the CMS Five-Star Quality Rating System).

58 Nursing staff capacity encompasses the nurse staffing hours per resident per day (HPRD) for certified nursing assistants (CNAs), licensed practical nurses (LPNs), and registered nurses (RNs).

59 Performance metrics also included the weighted health inspection score, a composite CMS metric based on state inspection results.

60 These data also include total penalties and payment denials. Incidents originate within the facility and are reported by the provider, while substantiated complaints are externally submitted by residents, families, or staff. Fines are monetary penalties for noncompliance with federal standards, and payment denials restrict reimbursement for new admissions due to serious or repeated deficiencies. Total penalties reflect the combined sum of incidents, fines, and payment denials. Our analysis included incidents, substantiated complaints, and fines, but excluded total penalties because it is a composite of the three. We also excluded fine totals, due to the likely correlation with facility size, which was already captured by bed count; and payment denials, due to correlation with other penalties and underlying deficiencies. *See Nursing Homes Including Rehab Services: Technical Details*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://data.cms.gov/provider-data/topics/nursing-homes/technical-details [https://perma.cc/AC4B-DWAY] (last visited June 9, 2026) (providing descriptions of the data included in some of these categories); CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 49 (same).

61 Arithmetic for converting regression outputs to odds is detailed in the Supplemental Appendix.

hours per resident per day (HPRD).[62] To capture how facility performance relative to state norms influences loan receipt, we incorporated both facility-level characteristics and the corresponding state-year average values for those same measures.[63] Regression variables were retained using backward stepwise selection, keeping only those predictors with a *p*-value less than 0.15.[64] All predictors for state-year average values were retained, however, to control for state-level trends.

To evaluate the effect of loan receipt on facility performance, we conducted a difference-in-difference analysis using ordinary least squares regression. This approach estimated changes in nursing home characteristics—bed count, CMS Five-Star Quality Ratings, HPRD, and regulatory penalties—comparing the four years before and after loan approval. Analysis included facility- and year-fixed effects of all nursing homes.[65]

B. Findings

Our analysis reveals that the Section 232 program during the study period was dominated by refinancing and acquisition activity rather than new

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62 The survey rating was excluded in logistic regression because it is correlated with the weighted health inspection score, and overall rating was excluded to avoid redundancy with other correlated metrics already in the analysis.

63 To evaluate how loan recipients differ from the broader state context, the regression model included each facility-level characteristic alongside a second term representing the average value of that characteristic across all nursing homes in the same state during the facility's index year. For example, a facility with an RN HPRD of 1.0 in a year when its state's average RN HPRD was 0.8 contributes two predictors to the model: the facility's RN HPRD and the state-year average RN HPRD. Including both terms allows the facility-level coefficient to be interpreted as the effect of staffing relative to the state's overall staffing environment. Both facility-level and state-level variables were transformed using a log base-2 scale to ensure consistent interpretation (i.e., coefficients represent the effect of a doubling of the underlying measure).

64 Specifically, to limit inclusion of statistically insignificant or confounding variables, we selected variables for removal based on the largest *p*-value, which represented the likelihood of a spurious finding. We began regression with all variables, including facility characteristics, provider type, performance metrics, and census tract statistics. We then removed data from the variable with the largest *p*-value and re-ran the regression. We continued this process until all variables that remained had a *p*-value of less than 0.15. Doing so resulted in a final model with similar variable effects to the initial model but with improved interpretability following the removal of variables that contribute little predictive value.

65 Difference-in-difference analysis uses linear regression methods to estimate average treatment effect for a given statistic (e.g., change in bed count from pre- to post-loan) while controlling for fixed effects at the nursing-home and calendar-year levels. By incorporating fixed effects by year, the analysis can separate national trends in each statistic (e.g., increasing bed counts over time for all facilities) from period effects. Similarly, by incorporating fixed effects at the facility level, the analysis accounts for baseline facility characteristics (e.g., large facilities with higher bed counts) and estimates the change in that facility's bed count across periods. *See generally* Coady Wing, Kosali Simon & Ricardo A. Bello-Gomez, *Designing Difference in Difference Studies: Best Practices for Public Health Policy Research*, 39 ANN. REV. PUB. HEALTH 453 (2018) (describing difference-in-difference analyses).

construction or substantial rehabilitation, with the overwhelming majority of loans issued under Section 223(f). This, along with our other findings, raises questions about whether the current administration of the Section 232 program is aligned with its stated goals of improving access to capital in the nursing home context in ways that enhance quality of care and resident well-being.

1. Types of Loans

Section 232 insures several different kinds of loans. Section 223(f) loans are primarily for acquisition or refinancing and cannot be used for "[p]rojects requiring a level of repairs that constitutes substantial rehabilitation."[66] HUD has defined "a substantial rehabilitation project" as one where "[t]he hard costs of repairs, replacements, and improvements (not including major movable equipment) exceeds 15% of the project's value after completion of all repairs, replacements, and improvements" or where "[t]wo or more major building components are being substantially replaced."[67] By contrast, New Construction/Substantial Rehabilitation (NC/SR) loans can be used for new construction, when no work has been done prior to issuance, or for substantial rehabilitation of existing projects.[68] And Supplemental 241(a) loans are available to finance improvements or additions to an existing project insured by Section 232 (including the addition of new beds); to provide financing for furniture and major movable equipment; or to finance energy conservation improvements.[69]

By far the most common type of loan during the time period examined was the 223(f) loan. From 2016 to 2024, 85.4% of the loans were 223(f) loans, and 10.2% of loans refinanced existing 223(f) loans (see Table 1).

66 SECTION 232 HANDBOOK, *supra* note 32 § 2.9(B).

67 *Id.* § 2.6(B).

68 *Id.* § 2.6(A)–(B).

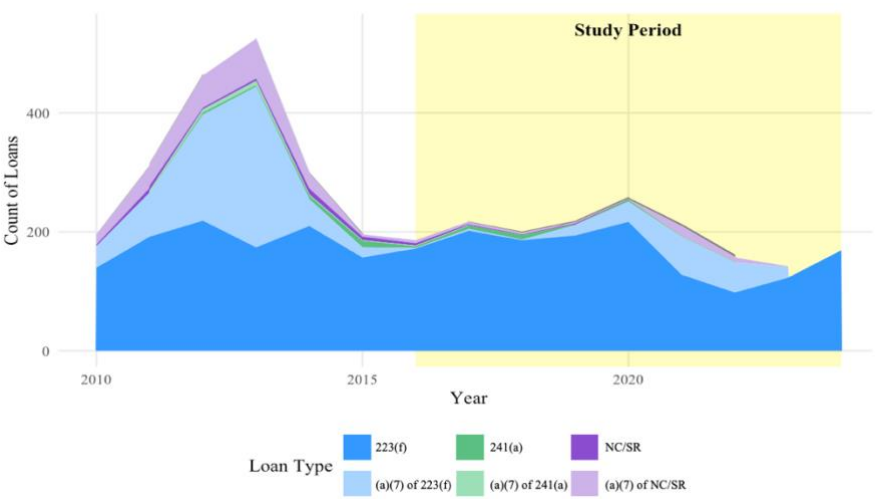
69 *Id.* §§ 2.4(E), 2.8. In addition to these three types of loans and 223(a)(7) loans for refinancing these loans, HUD provides loans to purchase and install fire safety equipment, primarily fire sprinkler systems (232(i)); and to support operating losses (223(d)). *Id.* § 2.10 (describing 223(a)(7) loans); *id.* § 2.12 (232(i) loans); *id.* § 2.11 (223(d) loans). From 2016 to 2024, just five 223(d) loans and one 232(i) loan were approved. *See* U.S. DEP'T OF HOUS. & URB. DEV., *supra* note 47. We thus do not include them in our analysis.

TABLE 1. COUNT OF LOANS FROM 2016–2024 AND AVERAGE LOAN VALUE

Loan Type	Count (N)	Proportion (%)	Average Value (millions)
223(f)	1,502	(85.4%)	$13.1
223(f) refinancing under 223(a)(7)	179	(10.2%)	$11.5
241(a)	20	(1.1%)	$6.9
241(a) refinancing under 223(a)(7)	6	(0.3%)	$6.5
NC/SR	11	(0.6%)	$17.9
NC/SR refinancing under 223(a)(7)	35	(2%)	$13.7
Two-year operating loss	5	(0.3%)	$1.0
Fire safety	1	(0.1%)	$1.1

Refinancing loans were more common prior to the study period between 2010 and 2015, likely due to low interest rates during that period, while new 223(f) loan volume remained relatively stable over time (see Figure 2).

FIGURE 2: CUMULATIVE FREQUENCY OF LOANS OVER TIME BY TYPE[70]



Notably, a substantial number of 223(f) loans were approved in what we have classified as "batches"—loans issued on the same date by the same

70 The frequency of loans is depicted as an area plot with the height of each color representing the number of loans for that year.

primary and secondary lenders (see Table 2). Among 223(f) loans, 56.2% were approved on the same date with at least one other loan from the same lenders, and nearly a third were approved with four or more loans (see Table 2).[71]

TABLE 2. FREQUENCY OF BATCH SIZE FOR 223(F) LOANS FROM 2016–2024

Batch Size	Count of Loans with Batch Size (N)	Proportion of Loans (%)
1	658	43.8%
2	216	14.4%
3	165	11.0%
4	100	6.7%
5	115	7.7%
6	84	5.6%
7	14	0.9%
8	40	2.7%
9	9	0.6%
10+	101	6.7%

2. Factors Associated with Receiving 223(f) Loans

The large volume of 223(f) loans provided us with the opportunity to engage in analysis of statistically significant factors associated with receiving a Section 223(f) loan. By contrast, the small volume of other types of Section 232 loans precluded meaningful analysis. This subsection therefore shares our findings of factors associated with 223(f) loan receipt only.

a. Ownership Status

Most nursing homes receiving Section 232 loans are owned by for-profit entities.[72] Of 223(f) loans, 92% were granted to for-profit nursing homes.[73] For-profit participation in the program is high, with more than one in ten of all for-profit homes receiving an approved loan in our study period (see Figure 3). Indeed, in most Northeast states, more than 20% of all for-profit nursing homes received a Section 232 loan (see Figure 3). Meanwhile, in thirty-two states (including Washington D.C.), no Section 223(f) loans were issued to nonprofit or government-owned nursing homes.[74] Only three

71 This latter figure can be calculated by summing the "Proportion of Loans" figures across all rows with a batch size of four or greater.

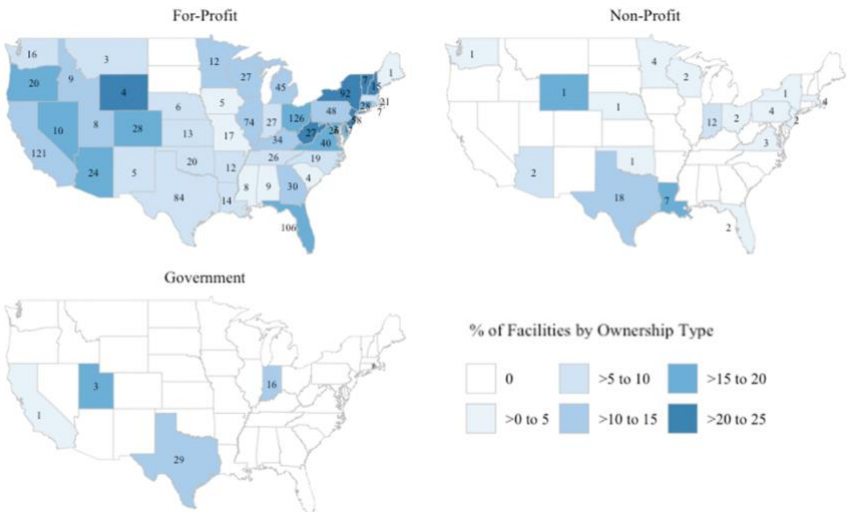
72 *See infra* Exhibit 1.

73 *See infra* Exhibit 1.

74 *See infra* Figure 3.

states—Indiana, Texas, and Louisiana—had more than five nonprofit or government-owned loan recipients (see Figure 3).

FIGURE 3: NURSING HOMES BY OWNER TYPE WITH 223(F) LOANS[75]



Our regression analysis revealed that for-profit ownership structure also increased the odds of loan receipt. Compared to for-profit nursing homes, nonprofit homes were 81% less likely and government-owned homes were 50% less likely to receive Section 232 loans.[76] Again, when evaluating homes receiving 223(f) loans, about 12% of all for-profit facilities in the country received them between 2016 and 2024, while less than 2% of nonprofit homes and less than 5% of government-owned homes received such loans during that time period.[77]

b. Facility Size and Payment Source

Nursing homes receiving 223(f) loans strongly tended to have more beds as well as higher occupancy rates compared to homes that did not receive any Section 232 loan.[78] In regression analysis, doubling the number

75 Each number within the state represents the number of nursing homes with 223(f) uptake by ownership category. The color density then represents the fraction of nursing homes of a particular ownership type that obtained a 223(f) loan from 2016 to 2024 (e.g., the eighty-four for-profit nursing homes in Texas account for five to ten percent of all for-profit nursing homes in Texas). Alaska and Hawaii are omitted from the figure to preserve its layout; both states have zero government or nonprofit loans, and Alaska and Hawaii have zero and two for-profit loans, respectively.

76 *See infra* Exhibit 2.

77 *See* Supplemental Appendix Exhibit A9.

78 *See infra* Exhibit 1.

of beds increased the likelihood of a facility receiving a loan by 1,097%, while a 10% increase in occupancy raised the likelihood by 44%.[79] Nearly all 223(f) recipients were certified for both Medicare and Medicaid, with only twenty-seven certified for Medicare alone and just two certified for Medicaid alone.[80]

c. Quality Measure Rating

Nursing homes with higher quality measure ratings (standardized scores assigned by CMS, which are then factored into the "Five-Star" overall rating publicized to consumers) were more likely to receive a 223(f) loan, and this relationship held both within and across states. In regression analysis, doubling a facility's quality measure rating relative to the average rating in its state and year increased the odds of loan receipt by 10%.[81] This pattern also held at the state level: facilities located in states with higher average quality measure ratings were substantially more likely to receive a loan; doubling the state-year average resulted in a 72% increase in the odds of loan receipt.[82] Unlike weighted health inspection scores and staffing (discussed further below), quality measure ratings moved in the same direction at both the facility and state level, suggesting that loans tend to flow toward facilities performing better on this particular metric.[83] Specifically, at the time of loan approval, nursing homes who had received Section 232 loans showed slightly better quality performance compared to the national average (3.8 vs. 3.6 quality measure rating).[84] This trend held even after adjusting for state-level differences and other quality measures such as other CMS performance variables, nursing staff capacity, and penalties data.

d. Weighted Health Inspection Score

The relationship between weighted health inspection scores and loan receipt was more mixed. Recall that a higher weighted health inspection score reflects a greater number or severity of cited deficiencies. At the facility level, doubling this score relative to the average rating in a facility's state and year was associated with a 16% reduction in the odds of receiving a loan, though this association was only marginally statistically significant.[85] At the state level, however, the relationship reversed: facilities located in

79 *See infra* Exhibit 2.

80 *See infra* Exhibit 1.

81 *See infra* Exhibit 2.

82 *See infra* Exhibit 2.

83 One factor potentially affecting this finding is Section 232's requirement that facilities demonstrate financial stability and operator experience, and the ineligibility of nursing homes designated as Special Focus Facilities. *See supra* notes 33–37 and accompanying text.

84 *See infra* Exhibit 1.

85 *See infra* Exhibit 2.

states with higher average weighted health inspection scores were significantly more likely to receive a loan, with a 100% increase in the state-year average associated with a 33% *increase* in the odds of loan receipt.[86] As with staffing (see below), this divergence suggests that while loans may modestly favor better-performing facilities relative to their in-state peers, loan volume overall is concentrated in states with weaker average inspection performance.

e. Staffing

After adjusting for state-level nurse staffing norms, nursing homes receiving 223(f) loans exhibit lower staffing rates compared to non-recipients as measured by HPRD.[87] Facilities located in states with higher average registered nurse (RN) hours per resident per day (HPRD) were substantially more likely to receive a loan: a doubling of the state-year average RN HPRD relative to the average rating in its state and year increased the odds of loan receipt by 238%.[88] In contrast, within those same states, facilities with higher RN HPRDs were significantly less likely to receive a loan than those with lower RN HPRDs. A doubling in facility-level RN HPRD reduced the odds of receiving a 223(f) loan by 83%, with a similar, but attenuated reduction in odds for increases in certified nursing assistant (CNA) and licensed practical nurse (LPN) HPRD.[89]

f. Penalties

Nursing homes receiving 223(f) loans report fewer facility-reported "incidents," defined as events that may affect resident health or safety and which must be reported to regulatory authorities.[90] These homes also had fewer reported fines (though more substantiated complaints).[91]

g. Location

Although facilities with 223(f) loans had a slightly lower average white population in their census tracts (72% vs. 74%), regression analysis showed they were located in census tracts with a higher percentage of white residents after accounting for facility characteristics and performance metrics.[92]

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86 *See infra* Exhibit 2.

87 *See infra* Exhibit 1.

88 *See infra* Exhibit 2.

89 *See infra* Exhibit 2.

90 *See infra* Exhibit 1; *supra* note 60 (explaining incidents).

91 *See infra* Exhibit 1. Nursing homes that fail to comply with federal standards set forth in the Nursing Home Reform Act of 1987 are subject to penalties, including civil monetary fines. *See* Kohn et al., *supra* note 2, at 147–55 (describing the penalties incurred through failure to comply with federal standards under the Nursing Home Reform Act of 1987).

92 *See infra* Exhibit 1 and Exhibit 2.

Specifically, after accounting for all other variables, a 10% increase in white population was associated with an 8% higher chance of receiving a loan.[93] This indicates that upon comparing nursing homes with 223(f) uptake to similar nursing homes without, uptake tends to occur in census tracts that are more white. In addition to race, facilities that received 223(f) loans tended to be in census tracts with higher median incomes and lower health insurance coverage, though the association with income was not statistically significant.[94]

h. Changes Following Loan Insurance

Concerningly, within four years following the receipt of a 223(f) loan, nursing staff levels at those homes decreased and the number of nursing home penalties increased. Difference-in-difference analysis comparing the four years before and after the receipt of a loan showed statistically significant changes in facility characteristics. Most notably, among all homes that received 223(f) loans, the RN HPRD declined by 7.3% relative to the average for those homes (see Table 3). This decrease was accompanied by reductions in CNA HPRD (-1.2%) (see Table 3). Additionally, the survey rating decreased by 2.2% relative to the average for those homes—indicating a higher frequency of regulatory penalties after the loan (see Table 3). Moreover, the number of certified beds increased by 0.3% (see Table 3).

By contrast, the average quality measure rating for homes that received Section 223(f) loans increased slightly relative to the four years preceding the loan date (see Table 3). However, quality measure ratings are based on self-reported data, and there is reason to be concerned that these ratings are influenced by facilities manipulating the underlying data to boost ratings; by contrast, penalties are the result of independent review.[95] Thus, it is difficult to find reassurance from recipient homes seeing slight improvements in average quality ratings, especially when there are increases in penalties levied and decreases in RN staffing.

93 *See infra* Exhibit 2.

94 *See infra* Exhibit 1.

95 *See, e.g.*, T. Edelman, *Quality Measure Ratings for Nursing Homes Fraudulently Boost Overall Ratings*, CTR. FOR MEDICARE ADVOCACY (Mar. 19, 2026), https://medicareadvocacy.org/quality-measure-ratings-for-nursing-homes-fraudulently-boost-overall-ratings [https://perma.cc/F8E6-XUVQ].

TABLE 3. CHANGE IN NURSING HOME CHARACTERISTICS FROM FOUR YEARS PRIOR TO, AND FOLLOWING RECEIPT OF, A 223(F) LOAN

Variable	Average Prior to Loan[96]	Change *(95% confidence interval)*	Significance[97]	Relative Percentage Change[98]
Bed Count *(Beds)*	123.5	0.43 *(0.16, 0.7)*	**	0.3%
Overall Rating *(5-point rating)*	3.1	-0.04 *(-0.09, 0.01)*		-1.2%
Quality Measure Rating *(5-point rating)*	3.8	0.05 *(0, 0.09)*	~	1.2%
Survey Rating *(5-point rating)*	2.8	-0.06 *(-0.11, -0.01)*	*	-2.2%
Staffing Rating *(5-point rating)*	2.6	-0.03 *(-0.06, 0.01)*		-1.0%
RN *(HPRD)*	0.5	-0.04 *(-0.05, -0.03)*	***	-7.3%
LPN *(HPRD)*	0.9	0.00 *(-0.01, 0.01)*		-0.2%
CNA *(HPRD)*	2.2	-0.03 *(-0.04, -0.01)*	**	-1.2%
Weighted Health Inspection Score	58.39	1.83 *(-1.3, 4.97)*		3.1%

C. Study Limitations

This study has a few limitations worth noting. First, we cannot observe nursing homes that applied for Section 232 loans and were denied, nor those that may have been eligible but never applied. Second, we lack data on facilities that received financing from alternative sources, so our picture of financing access is incomplete. That said, given that our focus is on whether Section 232 specifically is being administered in a way that promotes its objectives, our lack of insight into other sources of financing is

96 Pre-loan averages are taken from the quarter immediately preceding loan approval. *See infra* Exhibit 1.

97 The asterisks stand for various statistical significance values: *** (p-value < 0.01%); ** (p-value < 1.0%); * (p-value < 5.0%); and ~ (p-value < 10.0%).

98 Relative percentage change is calculated by dividing the absolute post-loan change (third column from left)—measured over the four years after loan approval compared to the four years before—by the average value of each characteristic in the pre-loan quarter.

not of substantial importance. Third, our analysis focuses on 223(f) loans, which comprised most of the loans during our period, but excludes other loan types, potentially omitting distinct effects related to construction or substantial rehabilitation. Fourth, because the study period ends in 2024, many loans issued after 2020 lack a full four years of follow-up, limiting the power of our difference-in-difference analysis. Fifth, although our evaluation of approval patterns across lenders and across time shows repeated clusters of geographically and organizationally related facilities receiving loans on the same day—strongly supporting the possibility of portfolio-level debt restructuring—this interpretation cannot be confirmed without data sources to which we lack access.[99] Lastly, we rely on census tract-level data from 2017 to 2021, which may not reflect demographic shifts that occurred after that time. None of these limitations gives us reason to question the findings articulated above.

III
ASSESSING SECTION 232'S EFFICACY IN LIGHT OF STUDY FINDINGS

Section 232 has the potential to serve as a powerful federal financing tool—one capable of expanding access to capital in underserved communities, supporting facilities with limited private financing options, and incentivizing investments that improve nursing home quality of care. Whether the program in practice fulfills these objectives, however, depends on three considerations: (1) how loans are distributed across communities and facility types; (2) the extent to which financing reaches providers with the greatest capital needs; and (3) whether insured loans are associated with improvements in staffing and resident outcomes. This Part examines each of these questions in turn.

A. Does Section 232 Support Marginalized Communities?

Our findings suggest that Section 232 is not adequately serving marginalized communities. Specifically, our findings show that Section 232 loans are disproportionately received by nursing homes located in communities with a greater proportion of white residents. While our analysis does not reveal the mechanisms for this disparity, possible drivers might include real-estate dynamics (e.g., high property value), awareness of the program, more favorably inclined lenders, or other factors affecting facility financials. Regardless, this trend suggests that markets serving more racially and socially vulnerable populations may be more likely to be excluded from

[99] Given the limited number of lenders, it is also possible that unrelated facilities were approved on the same date or that HUD or lenders internally process Section 232 loans in batches. However, additional analysis presented in the Supplemental Appendix suggests this is unlikely.

the capital access benefits provided by Section 232. This is inconsistent with the common justifications provided for the program's existence.[100] Moreover, it raises substantial concerns that Section 232 may reinforce existing inequities in long-term care. Prior studies have shown that nursing homes that disproportionately serve Black and Hispanic residents are associated with lower quality of care, including a lower quality of life and a greater risk of the spread of infectious disease.[101] Without targeted adjustments, the program risks perpetuating disparities in a healthcare system already marked by significant structural inequities.

The degree to which Section 232 uptake patterns reinforce existing racial inequalities will depend, at least in part, on the relative racial makeup of the homes that receive Section 232 loans. A 2025 study published by Robert Tyler Braun and his coauthors in the *Journal of the American Medical Directors Association* did not find a difference in the racial makeup of residents between homes that received Section 232 loans and those that did not.[102] However, that study compared the racial makeup of residents in nursing homes that received Section 232 loans with that of residents in nursing homes that had occupancy rates above 85% but did not receive such loans.[103] The authors explained that this threshold was "chosen to capture facilities most similar to . . . [Section] 232 . . . recipients and thus most likely to be eligible for a HUD loan."[104] Given the substantial literature on differences between homes that serve largely minority populations and those that do not,[105] however, only comparing homes "most similar"[106] to Section 232-insured homes may obscure racial trends in the receipt of a Section 232 loan. Additionally, the analysis provided by Braun and his coauthors demonstrates that the number of Medicare beneficiaries is a strong predictor of Section 232 uptake.[107] This may confound their observed lack of influence of racial composition on program uptake given varying representation of non-white groups in Medicare.[108] Unlike Braun and his coauthors, we do not

100 *See supra* notes 16–28 and accompanying text.

101 *See* Tetyana P. Shippee, Weiwen Ng & John R. Bowblis, *Does Living in a Higher Proportion Minority Facility Improve Quality of Life for Racial/Ethnic Minority Residents in Nursing Homes?*, 4 INNOVATION AGING, no. 3, 2020, at 7 (discussing racial and ethnic disparities in quality of life); Robert Weech-Maldonado, Justin Lord, Ganisher Davlyatov, Akbar Ghiasi & Gregory Orewa, *High-Minority Nursing Homes Disproportionately Affected by COVID-19 Deaths*, 9 FRONTIERS PUB. HEALTH, Mar. 2021, at 4–5 (providing data reflecting elevated incidences of COVID-19 in nursing homes with higher levels of minorities).

102 Braun et al., *supra* note 15, at 5–6.

103 *Id.* at 2.

104 *Id.*

105 *See generally* Shippee, Ng & Bowblis, *supra* note 101 (discussing racial and ethnic disparities in quality of life).

106 Braun et al., *supra* note 15, at 2.

107 *Id.* at 5.

108 *See generally* KAISER FAM. FOUND., PROFILE OF MEDICARE BENEFICIARIES BY RACE AND

incorporate facility-level race or Medicare status of residents.

Moreover, racial disparities in the geographic communities served by Section 232 compared to those not served by Section 232 would be concerning even if such differences were not seen at the level of individual facilities. The community in which a nursing home is located is the likely source of future residents of the facility. In the long term, knowing the racial composition of the community in which a facility is located this year is important to predict who it will serve in the years to come.[109]

B. Does Section 232 Support Homes in Need of Capital?

Our analysis finds that Section 232 supports homes in accessing capital, but appears to be disproportionately supporting facilities that may least need that support. Specifically, our findings indicate that Section 232 loans go primarily to larger, for-profit nursing homes that disproportionately serve Medicare-covered residents.[110] By comparison, uptake of type 223(f) loans (the most common loan type) among nonprofit and government-owned facilities was limited and uneven, with thirty-two states (including Washington D.C.) reporting no participation from either group, and only three states reporting uptake by more than five such facilities.[111]

By looking at loan type, our findings also provide new insight into the types of activities Section 232 subsidizes. Specifically, our findings indicate that Section 232 is primarily used as a refinancing tool rather than a mechanism for supporting nursing home improvements or new development. Most loans approved from 2016 to 2024 (85.4%) were 223(f) loans, which are typically used to refinance or purchase existing facilities. An additional 10.2% of loans were used to refinance prior 223(f) loans. Meanwhile, loans directed toward new construction or substantial rehabilitation (0.6%), or facility upgrades (1.1%), were exceedingly rare.

By comparing nursing homes that received Section 232 loans to those that did not, we were also able to identify some quality differences between the two. Specifically, we observed that loans are more likely to go to nursing

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ETHNICITY: A CHARTPACK (2016), https://www.kff.org/medicare/profile-of-medicare-beneficiaries-by-race-and-ethnicity-a-chartpack [https://perma.cc/DR3P-AYHD] (profiling the Medicare population through the lens of race and ethnicity).

109 *See* David Barton Smith, Zhanlian Feng, Mary L. Fennell, Jacqueline S. Zinn & Vincent Mor, *Separate and Unequal: Racial Segregation and Disparities in Quality Across U.S. Nursing Homes*, 26 HEALTH AFFS. 1448, 1451–52 (2007) (observing that Black Americans are concentrated in a small percentage of nursing homes).

110 This finding is consistent with that of Braun and his coauthors. *See* Braun et al., *supra* note 15, at 5–6.

111 It is admittedly difficult to determine what conclusion to draw from the lack of insurance uptake by government-owned facilities. It could well be that government-owned nursing homes have access to alternative funding sources, such as municipal bonds. It might also reflect reduced administrative capacity to pursue Section 232 loans.

homes with stronger quality measure ratings and health inspection scores relative to their in-state peers. Notably, our results diverge from Braun and his coauthors, who found no association between loan uptake and quality or health deficiencies.[112] The difference in our findings may stem from differences in nursing home sampling. Their exclusion of the 17% of nursing homes with occupancy under 85% is designed to limit comparisons of Section 232 uptake to similarly performing facilities.[113] Additionally, their analysis did not include the quality measure rating, a measure of clinical outcomes, and they also collapsed the overall rating (scores ranging from one to five) into a binary (i.e., above vs. below three), which may have limited sensitivity to small differences.[114]

The implications of these small differences in quality metrics are unclear. On the one hand, directing money toward higher performers may encourage good performance and support facilities that are providing better service to residents. On the other hand, those struggling with quality may need greater support. Given that quality measure ratings are based largely on self-reported data, it is also possible that the differences stem not from true quality differences, but from differences in reporting behaviors (perhaps with Section 232 recipients engaging in more strategic reporting behavior).

We also uncovered loan approval patterns suggesting that many loans are issued in large batches, likely reflecting portfolio-level debt restructuring by corporate owners. Nearly a third of loans were part of batches involving four or more facilities, approved on the same day by the same lenders, suggesting strategic refinancing rather than targeted capital expansion for underserved facilities.

Collectively, these findings suggest that Section 232 is not effectively serving its goal of expanding capital access to facilities most in need. Rather, it may be providing the greatest assistance to large, sophisticated owners who are least in need of such a subsidy.

C. Does Section 232 Improve Nursing Home Quality?

Our findings do not show that Section 232 improves the quality of care that nursing home residents receive. Although they did show that nursing homes that receive Section 232 loans have slightly improved aggregate quality measure ratings following loan receipt, as previously discussed, quality measure ratings are a self-reported measure, and their

112 Braun et al., *supra* note 15, at 6.

113 *Id.* at 2. Statistics derive from Braun and his coauthors' supplementary figures, which indicate 15,397 initial nursing homes. After restricting to counties with HUD loans, 8,377 remain; applying an over 85% occupancy filter yields 6,943 homes, excluding 1,434 (17.1%).

114 *Id.* at 5–6.

accuracy has been called into serious question.[115]

By comparison, nurse staffing levels, an objective measure of nursing home performance, demonstrated worse performance among loan recipients. Prior to loan receipt, facilities had significantly lower staffing levels—including lower RN, CNA, and LPN HPRD—and thus a lower average total staffing rating (2.6 vs. 3.1).[116] And following loan receipt, staffing ratings declined by 0.03 stars on average following the loan, with a notable 7.3% decrease in RN HPRD relative to baseline levels. These declines suggest that insured loans do not drive meaningful quality improvements. The reduction in staffing metrics may reflect cost-cutting behaviors often associated with for-profit ownership structures.[117] This is concerning as numerous studies have shown that lower HPRD is associated with lower quality of care and worse resident outcomes.[118]

An additional objective measure, survey ratings, declined by 0.06 stars on average following loan receipt, which reflects more fines, reportable incidents, or substantiated complaints. There are several possible explanations for these declines. It could be that facilities receiving loans temporarily improved performance to help secure a Section 232 loan before regressing to prior norms. A more likely explanation is that Section 232 loans are secured as part of a larger package of financial changes that facilities undertake to enhance facility profitability, and the other changes cut costs in ways that undermine quality. Since Section 232 loans often are tied to facility acquisitions, these financial restructuring changes might reflect new management introducing profit-seeking policies that disrupt quality of care.

These results are concerning. As discussed above, 223(f) loans are

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115 *See supra* note 95 and accompanying text.

116 These results persisted after adjusting for facility size and other covariates and align with Braun and his coauthors' findings that a higher RN HPRD decreased the likelihood of receiving Section 232 loans. *See* Braun et al., *supra* note 15, at 6.

117 Sean Campbell & Charlene Harrington, *For-Profit Nursing Homes Are Cutting Corners on Safety and Draining Resources with Financial Shenanigans—Especially at Midsize Chains that Dodge Public Scrutiny*, CONVERSATION (Mar. 14, 2024, at 8:46 AM ET), https://theconversation.com/for-profit-nursing-homes-are-cutting-corners-on-safety-and-draining-resources-with-financial-shenanigans-especially-at-midsize-chains-that-dodge-public-scrutiny-225045 [https://perma.cc/3E2B-59BD] ("The for-profit nursing home sector is growing, and it places a premium on cost cutting and big profits . . . ."); *see also* MICH. ELDER JUST. INITIATIVE & NAT'L CONSUMER VOICE FOR QUALITY LONG-TERM CARE, PUBLIC FUNDS INTO PRIVATE POCKETS: HOW NURSING HOMES MAY BE HIDING PROFITS AND DEPRIVING RESIDENTS OF CARE AND QUALITY 4–7 (2025) (discussing the diversion of money to profits and away from wages for facility staffing).

118 *See, e.g.*, ALAN J. WHITE ET AL., CTRS. FOR MEDICARE & MEDICAID SERVS., NURSING HOME STAFFING STUDY: COMPREHENSIVE REPORT 11–12, 50–55 (2023) (collecting sources); *see also* Dana B. Mukamel, Debra Saliba, Heather Ladd & R. Tamara Konetzka, *Association of Staffing Instability with Quality of Nursing Home Care*, JAMA NETWORK OPEN, Jan. 10, 2023, at 1 (showing that day-to-day staffing instability was an important contributor to quality of care in nursing homes).

not intended for major facility upgrades, but they do allow for moderate capital improvements. Given this, we hypothesized that some quality improvements might follow modest facility upgrades or better access to capital. However, this was not supported by the data.[119]

In sum, nursing homes receiving Section 232 loans consistently operate with fewer nursing staff than the national average and experience further staffing declines after loan approval. While these homes maintained above-average quality measure ratings and fewer incidents, this may reflect a strategic emphasis on operational efficiency rather than actual improvements in quality of care. Overall, Section 232 loan uptake appears associated with cost-reduction strategies rather than enhanced care quality, raising concerns about the program's alignment with federal goals to improve nursing home standards.

IV
REFORMING SECTION 232 TO EXPAND ACCESS AND PROMOTE QUALITY

As we explain in Parts II and III, there is little indication that Section 232, as currently operated, is targeting support to those facilities most in need of capital. Rather, our findings suggest that the program is less utilized in racial minority areas and is primarily utilized by for-profit operators, many of which likely have existing access to capital. Nor is there any indication that Section 232 is improving resident outcomes. Instead, our findings show that loan receipt is associated with notable decreases in RN HPRD and increases in the number of penalties, while also not being associated with measurable improvements in health outcomes.

To better fulfill its intended purposes, Section 232 should be restructured to encourage participation from high-need and high-performing facilities. Currently, the program's administrative processes and eligibility criteria disproportionately benefit large, for-profit facilities while excluding their small, nonprofit, or under-resourced counterparts—perhaps especially those serving low-income populations and racial minorities. Of course, casting a wider net could increase Section 232's losses, if only by encouraging a greater volume of loans. However, our findings suggest that doing so is necessary in order for Section 232 to achieve its stated policy objectives.

First, HUD should remove structural barriers to participation by small nursing homes. Currently, nursing homes with under twenty beds are wholly ineligible for Section 232 loans under HUD guidance.[120] This is undesirable

[119] Bed capacity, however, increased slightly by 0.43 beds, perhaps indicating some reinvestment into the facility. *See supra* Table 3.

[120] SECTION 232 HANDBOOK, *supra* note 32 § 2.2 (describing eligible projects as "consist[ing] of at least 20 beds"); *see also* 2025 DRAFT SECTION 232 HANDBOOK, *supra* note 32, at § 2.2.

given that smaller homes are often associated with better resident outcomes, and there is broad agreement that smaller, more home-like settings (such as "Green House" homes) should be encouraged.[121] Expanding eligibility to smaller homes would be consistent with the call by the National Academies of Sciences, Engineering, and Medicine for "[c]reating incentives for new construction and renovation of nursing homes to provide smaller, more home-like environments."[122] As the Academies have explained, smaller and more "home-like" facilities enhance quality of life and are more consistent with resident preferences.[123] They are associated with reduced risk of infection and thus would, among other things, reduce mortality risks in the event of a future public health emergency such as the COVID-19 pandemic.[124]

This change could be accomplished by revising the regulations governing eligibility for Section 232 loans to explicitly extend eligibility to small nursing homes, or, more simply, by amending HUD's Section 232 Handbook; the twenty-bed minimum is a matter of guidance rather than regulation. Accordingly, because the minimum-bed requirement is not codified in statute or the Section 232 regulations themselves, HUD could modify or waive this eligibility criterion through a routine revision of the Section 232 Handbook, consistent with its existing regulatory authority to define eligible projects and underwriting standards.[125] Such a revision would not require congressional action and could be implemented in a targeted, administratively straightforward manner, permitting smaller nursing homes to participate in the program as long as they meet the same specified quality, financial, and operational safeguards that other homes must currently meet.

HUD could even go one step beyond merely removing barriers to participation by smaller nursing homes and instead prioritize smaller facilities in the Section 232 Handbook. Consistent with the evidence discussed above regarding the relationship between smaller nursing homes and improved resident outcomes, HUD could incorporate size-based preferences into its consideration of applications, for example, by offering

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121 Rob Waters, *The Big Idea Behind a New Model of Small Nursing Homes*, 40 HEALTH AFFS. 378, 379 (2021) (describing Green Houses as having the capacity to provide older adults with "better quality of life while reducing hospital admissions, Medicare spending, and staff turnover"); NAT'L ACADS. OF SCIS., ENG'G & MED., *supra* note 4, at 7 ("Smaller, home-like environments play key roles in infection control and enhancing the quality of life for residents as well as staff.").

122 NAT'L ACADS. OF SCIS., ENG'G & MED., *supra* note 4, at 7.

123 *Id.* at 507.

124 *Id.* at 340, 507.

125 *See* 24 C.F.R. § 232.3 (2026) ("The borrower shall be a single asset entity acceptable to the Commissioner, as may be limited by the . . . Act, and shall possess the powers necessary and incidental to owning the project," with the exception "that the Commissioner may approve a non-single asset borrower entity under such circumstances, terms, and conditions determined and specified as acceptable to the Commissioner.").

streamlined review (like the "Express Lane" program briefly discussed in Part I), increased technical assistance, or even more favorable terms for facilities below a specified bed threshold. Such an approach would remain consistent with HUD's existing authority to shape program priorities and would better align Section 232 financing with quality-of-care objectives, rather than reinforcing a financing model that disproportionately favors larger institutional facilities.

Second, HUD should review and reconsider financial and performance eligibility criteria to reduce the likelihood that such criteria inadvertently disqualify facilities serving vulnerable populations, or make it more difficult to apply for, and secure, a Section 232 loan. Many, if not most, of these criteria come from HUD guidance rather than the regulatory scheme.[126] For example, most Section 232 loans require a minimum debt service coverage ratio of 1.45 to demonstrate that the nursing home generates sufficient cash flow to cover debt obligations.[127] The Section 232 Handbook also emphasizes that if borrowers are not structured as single-asset entities, they must demonstrate strong financial capacity and operational experience,[128] while facilities with Special Focus Facility designations are disqualified entirely.[129] These financial and performance criteria, though intended to protect HUD's insurance risk, systematically disadvantage smaller, nonprofit, or safety-net facilities in communities with high Medicaid reliance or minority populations. While HUD should not reward low-achieving nursing homes, homes in communities with high proportions of Medicaid-dependent or minority residents tend to have lower financial margins, more incidents, and lower staffing levels, reflecting, in part, systemic underfunding.[130] The current standards reward facilities that are already well-capitalized and high-performing while excluding those most in

126 *But see id.* Borrowers must also satisfy various requirements generally applicable to multifamily and health care facility mortgage insurance programs. *Id.* § 232.1(a).

127 SECTION 232 HANDBOOK, *supra* note 32, sec. II, ch. 3, § 3.2; *see also* 2025 DRAFT SECTION 232 HANDBOOK, *supra* note 32, sec. II, ch. 3, § 3.2.

128 SECTION 232 HANDBOOK, *supra* note 32, sec. II, ch. 2, § 2.5(C)(2); *see also* 2025 DRAFT SECTION 232 HANDBOOK, *supra* note 32, sec. II, ch. 2, § 2.5(C)(2).

129 SECTION 232 HANDBOOK, *supra* note 32, sec. II, ch. 2, § 2.3(F).

130 *See generally* Yejin Kang, Sam Kang, John R. Bowblis, Brian Downer, Matthew D. McHugh & Huiwen Xu, *Association of Racial and Ethnic Composition with Staff Levels in Nursing Homes: 2013–2019*, 26 J. AM. MED. DIRS. ASS'N, Apr. 2025, at 2 (describing limited resources available to Black and Hispanic residents relative to those available to white residents of nursing homes); Jasmine L. Travers, Nicholas Castle, Susan H. Weaver, Uduwanage G. Perera, Bei Wu, Andrew W. Dick & Patricia W. Stone, *Environmental and Structural Factors Driving Poor Quality of Care: An Examination of Nursing Homes Serving Black Residents*, 71 J. AM. GERIATRICS SOC'Y 3040 (2023) (concluding that modifications to staffing can positively improve the quality of care delivered to residents of nursing homes); David C. Grabowski, *The Admission of Blacks to High-Deficiency Nursing Homes*, 42 MED. CARE 456, 463 (2004) (stating that Black Americans "are disproportionately admitted to nursing homes with significantly greater government-assigned deficiency citations").

need of capital to improve. Such exclusions also limit nonprofit participation while favoring large corporate chains, an ownership pattern that is associated with lower quality of care in the long term.[131]

Third, HUD should streamline the Section 232 application process, which currently requires extensive legal, financial, and regulatory documentation that can be cost-prohibitive for smaller or independent operators. Although the Section 232 regulations establish only general eligibility and approval standards, the Section 232 Handbook imposes a highly detailed and resource-intensive submission process. Applicants must provide, among other materials, full architectural plans and specifications, environmental reviews compliant with the National Environmental Policy Act, comprehensive market and appraisal reports, audited or certified financial statements, detailed ownership and organizational documents, management and operating agreements, and extensive disclosures regarding prior participation and regulatory compliance.[132] In addition, the Handbook requires multiple third-party reports—often prepared by HUD-approved professionals—including appraisals, market studies, and environmental site assessments, substantially increasing upfront transaction costs.[133]

These requirements, while intended to mitigate insurance risk, disproportionately burden smaller, nonprofit, and safety-net facilities that lack in-house legal and financial teams or the capital to finance pre-application expenses. HUD could reduce these barriers by consolidating duplicative submissions, scaling documentation requirements based on project size or loan amount, expanding technical assistance, or creating a simplified application pathway for smaller facilities. Because these requirements are imposed through HUD guidance rather than regulation, such reforms could again be implemented through targeted revisions to the Section 232 Handbook without congressional action or formal rulemaking.

Fourth, HUD should establish a fast-track or preferential review process for applicants meeting priority health equity or performance metrics. Section

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131 *See generally* David C. Grabowski, Richard A. Hirth, Orna Intrator, Yue Li, John Richardson, David G. Stevenson, Qing Zheng & Jane Banaszak-Holl, *Low-Quality Nursing Homes Were More Likely than Other Nursing Homes to Be Bought or Sold by Chains in 1993–2010*, 35 HEALTH AFFS. 907 (2016) (finding that nursing homes that maintained common ownership had fewer quality problems than those that did not maintain common ownership); Charlene Harrington, Brian Olney, Helen Carrillo & Taewoon Kang, *Nurse Staffing and Deficiencies in the Largest For-Profit Nursing Home Chains and Chains Owned by Private Equity Companies*, 47 HEALTH SERVS. RSCH. 106 (2012) (finding evidence of greater deficiencies in for-profit nursing home chains compared to homes operating as nonprofits); U.S. GOV'T ACCOUNTABILITY OFF., GAO-11-571, PRIVATE INVESTMENT HOMES SOMETIMES DIFFERED FROM OTHERS IN DEFICIENCIES, STAFFING, AND FINANCIAL PERFORMANCE (2011), https://www.gao.gov/assets/gao-11-571.pdf [https://perma.cc/ARZ6-TZXC] ("On average, [private investment] and other for-profit homes had more total deficiencies than nonprofit homes . . . .").

132 *See* SECTION 232 HANDBOOK, *supra* note 32, at chs. 3–6.

133 *See id.* at ch. 3.

232 uptake is higher in rural areas and Medicare-certified nursing homes, both of which tend to be more white.[134] Instead, facilities operating in medically underserved areas or low-income neighborhoods—where access to private capital is limited—should be prioritized. In parallel, HUD could fast-track or offer reduced mortgage insurance premiums to applicants demonstrating high performance or investment in quality-of-care improvements. Examples include facilities with higher HPRD, strong Five-Star ratings, lower infection rates, or investments in resident-centered care models such as single-occupancy rooms or the Green House design.[135] A precedent for such targeted incentives exists in HUD's Green Mortgage Insurance Premium program, which has offered premium reductions for energy-efficient buildings.[136] A similar structure could be adapted to promote quality of care by tying insurance rates to resident well-being and outcomes.

Each of these reforms would help move Section 232 away from its current position as a passive insurance mechanism toward an active policy lever for improving nursing home quality and promoting equity. Thus, each would help to better align the program with the federal government's broader nursing-home-related policy objectives. Since the adoption of the Nursing Home Reform Act of 1987, the federal government has committed itself to setting quality-of-care standards for nursing homes nationwide, monitoring nursing homes for compliance, and using financial incentives and penalties to promote adherence.[137] To the extent that Section 232 is reformed to encourage practices that are associated with better resident outcomes, Section 232 could assist in these broader efforts. And even administrations generally skeptical of expanded regulation, such as the first Trump Administration, have shown some willingness to consider performance-based funding mechanisms in the long-term care space.[138]

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134 Braun et al., *supra* note 15, at 5 (finding rural nursing homes and those with more Medicare residents were more likely to receive Section 232 loans).

135 *See supra* note 121 and accompanying text.

136 U.S. DEP'T OF HOUS. & URB. DEV., *Mortgagee Letter 2022-13: Green Mortgage Insurance Premium (MIP) Program Guidance for the Office of Residential Care Facilities (ORCF)* (Aug. 18, 2022), https://www.hud.gov/sites/dfiles/OCHCO/documents/2022-13hsgml.pdf [https://perma.cc/8H6X-HYQE]. This program provides a model even though the Trump Administration has moved to end it. *See* U.S. DEP'T OF HOUS. & URB. DEV., *HUD Secretary Scott Turner Moves to Eliminate Green Housing Mandate*, https://www.hud.gov/news/hud-no-25-084 [https://perma.cc/4ZPB-8XHN] (last visited June 24, 2026).

137 The Nursing Home Reform Act of 1987 is now codified at 42 U.S.C. §§ 1395i-3, 1396r.

138 *See* Press Release, Ctrs. for Medicare & Medicaid Servs., Trump Administration Unveils Enhanced Enforcement Actions Based on Nursing Home COVID-19 Data and Inspection Results (June 1, 2020), https://www.cms.gov/newsroom/press-releases/trump-administration-unveils-enhanced-enforcement-actions-based-nursing-home-covid-19-data [https://perma.cc/X2AC-Y8R5] ("To ensure effective oversight is achieved, CMS will allocate the CARES Act funding based on performance-based metrics.").

CONCLUSION

Financial subsidies, like the Section 232 program, are one way the federal government responds to financial strains facing healthcare providers, and the corresponding concern that providers will become insolvent or decide for financial reasons not to serve communities in need.[139] If such subsidies are to be effective and efficient, policymakers must understand how subsidies are distributed and the incentives they create.

Unfortunately, though Section 232 has the potential to both help correct market failures in nursing home financing (especially in underserved regions) and incentivize nursing homes to improve their quality of care, our study reveals that Section 232 is falling short. Of the loans issued during our study period, most went to larger, for-profit facilities in more white census tracts, with little to no evidence of improvements in staffing or quality of care following the receipt of a loan. Indeed, nursing homes that receive Section 232 loans frequently make changes commonly associated with poorer quality care. The end result is that Section 232 may be reinforcing existing shortcomings in nursing home care rather than addressing them.

It is high time to reform Section 232 so that this program can achieve its core objectives that have justified the federal government's substantial financial investment. In this Essay, we have suggested a series of feasible and concrete reforms that could enable the program to support the types of facilities and communities most in need of capital.

Embracing these reforms would align Section 232 with the federal government's longstanding policy goal of improving nursing home quality of care. Given the continuing quality-of-care problems plaguing nursing homes in this country and the expanding financial investment in Section 232, reforms should be made without delay. Otherwise, the program will continue to serve primarily as a subsidy for larger nursing homes, missing the opportunity to support smaller nursing homes and encourage practices that could improve care for America's 1.2 million nursing home residents.[140]

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139 *See generally* Samuel Antill, Jessica Bai, Ashvin Gandhi & Adrienne Sabety, *Healthcare Provider Bankruptcies* 1 (Nat'l Bureau of Econ. Rsch., Working Paper No. 33763, 2025), https://www.nber.org/papers/w33763 [https://perma.cc/2XMS-JMWL] (discussing the record rates of healthcare firms filing for bankruptcy).

140 *See* Chidambaram & Burns, *supra* note 1.

ADDITIONAL EXHIBITS

EXHIBIT 1: DESCRIPTIVE STATISTICS FOR NURSING HOMES THAT RECEIVED 223(F) LOANS AS COMPARED TO THOSE THAT DID NOT RECEIVE ANY SECTION 232 LOAN

Variable	Nursing Homes without Section 232 Loans (n = 14,701)		Nursing Homes with 223(f) Loans (n = 1,464)			
	Mean or N	*SD or Percent*	*Mean or N*	*SD or Percent*	*Delta Mean or Percent*	*p-Value*
Nursing Home Characteristics						
Bed Count	101.9	59.1	123.5	64.4	21.5	***
% of Beds Filled	77%	16%	84%	12%	7%	***
Change of Ownership						
Yes	360	2%	37	3%	0.1%	
No	14,341	98%	1,427	98%	-0.1%	
In Hospital						***
Yes	13,963	95%	1,453	99%	4.2%	
No	738	5%	11	1%	-4.2%	
Ownership						***
For-profit	10,171	69%	1,348	92%	22.9%	
Government	1,047	7%	49	3%	-3.8%	
Nonprofit	3,483	24%	67	5%	-19.1%	
Certification						***
Medicaid	505	3%	2	0%	-3.3%	
Medicare	734	5%	27	2%	-3.2%	
Medicaid and Medicare	13,462	92%	1,435	98%	6.4%	
Nursing Home Performance						
CMS Five-Star Overall Rating	3.2	1.3	3.1	1.3	-0.1	~
CMS Five-Star Quality Measure Rating	3.6	1.2	3.8	1.1	0.2	***
CMS Five-Star Survey Rating	2.8	1.2	2.8	1.2	0.0	
CMS Five-Star Staffing Rating	3.1	1.2	2.6	1.0	-0.5	***
CNA HPRD	2.4	0.6	2.2	0.5	-0.2	***
LPN HPRD	1.0	0.4	0.9	0.3	0.0	**
RN HPRD	0.7	0.5	0.5	0.2	-0.2	***

Weighted Health Inspection Score	63.43	74.63	58.39	54.39	-5.0	*
Having a Fine						**
Yes	6,392	44%	584	40%	-3.6%	
No	8,309	57%	880	60%	3.6%	
Having a Substantiated Complaint						
Yes	9,824	67%	1,129	77%	10.3%	
No	4,877	33%	335	23%	-10.3%	
Having a Facility-Reported Incident						~
Yes	6,156	42%	570	39%	-3.0%	
No	8,545	58%	894	61%	3.0%	
Census Data, by Census Tract						
Age, Mean Years	41.2	7.8	41.3	7.8	0.1	
Total Population	4,216	1,570	4,376	1,536	160.5	*
White Population	74%	23%	72%	23%	-2%	*
Median Income	$66,456	$30,879	$68,041	$31,991	$1,585	
Proportion Population Insured	97%	5%	96%	5%	-1%	***
Lower than 10% Population Insured						
Yes	632	4%	64	5%	0.6%	
No	14,069	96%	1,400	95%	-0.6%	

The source of this table is our analyses of 2016–2024 nursing home CMS data, HUD Section 232 data, and 2017–2021 U.S. Census data. Mean values were derived from: (1) the average value of CMS nursing home data from 2016–2024; and (2) CMS nursing home data from the most recent quarter prior to loan receipt. The categorical data dimension was represented by the count and percentage of data points in each category.

Statistical significance values were calculated by *t*-test and chi-squared test:

*** denotes p-value < 0.01%;
** denotes p-value < 1.0%;
* denotes p-value < 5.0%; and
~ denotes p-value < 10.0%.

EXHIBIT 2: LOGISTIC REGRESSION COMPARING NURSING HOMES THAT RECEIVED A 223(F) LOAN WITH NURSING HOMES THAT DID NOT RECEIVE A SECTION 232 LOAN BY FACILITY CHARACTERISTICS, PERFORMANCE, AND CENSUS TRACT DATA

Variable	Percentage Change in Odds of Being a Loan Recipient	*p*-value
Nursing Home Facility Characteristics		
Bed Count (100% increase)	+1,097% (+607%, +1,928%)	***
Proportion Beds Filled with Residents (10% increase)	+44% (+37%, +51%)	***
Owned by Government Entity vs. Private Entity	-50% (-63%, -32%)	***
Owned by Nonprofit Entity vs. Private Entity	-81% (-86%, -76%)	***
Only Medicare-Certified Facility vs. Only Medicaid	+2,782% (+567%, +12,354%)	***
Both Medicare- and Medicaid-Certified Facility vs. Only Medicaid	+1,797% (+366%, +7,617%)	***
Nursing Home Facility Performance		
CMS Quality Measure Rating (100% increase)	+10% (+4%, +16%)	**
CMS Weighted Health Inspection Score (100% increase)	-16% (-31%, +1%)	~
CNA HPRD (100% increase)	-61% (-78%, -31%)	**
LPN HPRD (100% increase)	-48% (-64%, -26%)	**
RN HPRD (100% increase)	-83% (-88%, -74%)	***
Has a Substantiated Complaint	+27% (+9%, +47%)	**
Has a Fine	-17% (-27%, -6%)	**
Has a Facility-Reported Incident	-24% (-33%, -14%)	***
State-Year Average Facility Characteristics and Performance		
State-Year Average Bed Count (100% increase)	+9% (-15%, +40%)	

State-Year Average CMS Quality Measure Rating (100% increase)	+72% (+9%, +172%)	*
State-Year Average CMS Weighted Health Inspection Score (100% increase)	+33% (+18%, +49%)	***
State-Year Average CNA HPRD (100% increase)	-18% (-57%, +54%)	
State-Year Average LPN HPRD (100% increase)	+51% (-16%, +173%)	
State-Year Average RN HPRD (100% increase)	+238% (+88%, +507%)	***
Census Data, by Census Tract		
Proportion Population White (10% increase)	+8% (+5%, +11%)	***

The source of this table is our analyses of 2016–2024 nursing home CMS data, HUD Section 232 data, and 2017–2021 U.S. Census data averaged at the census tract level.

Reference values are 1.00. Estimates were derived from logistic regression classifying homes that have Section 232 loans versus those that do not. Our analysis utilized backward elimination of CMS and census data that contributed little to no effect to model prediction. Non-significant variables that were included were those that related to other highly significant variables in order to enable proper interpretation of effects.

Statistical significance values:

*** denotes p-value < 0.01%;
** denotes p-value < 1.0%;
* denotes p-value < 5.0%; and
~ denotes p-value < 10.0%.