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January/2012

President's Message

Happy New Year to the HFMA Chapter of New Mexico. During this time we reflect and recognize our accomplishments during the last year and set goals for ourselves in the year ahead.

I would like to take this opportunity to recognize a few individuals for their contributions and service to the chapter. As you may know, HFMA tracks activity in the chapter through Founders points and awards a Gold Silver and Bronze award based on level of activity in the chapter. The following have been selected to receive Founders awards for their service in 2011:



1. Renee Ennis - Muncie Gold Merit Award
2. Christopher Tyhurst - Reeves Silver Merit Award
3. Michael Nelson - Follmer Bronze Merit Award

Congratulations to these members on their achievement of these milestones and thank you for your service to the chapter.

This month we also received the results from our annual member satisfaction survey. HFMA rates the overall chapter scores based on the percentage of members that respond "very satisfied" in regard to our newsletter, educational programs and networking opportunities. This year I am pleased to report that we saw a 6% improvement over last year's score and recorded the highest satisfaction rating we've seen in the past four years. Your responses indicated a 45% very high satisfaction rating vs. a national target of 55%. Among the areas where we saw the greatest increase in satisfaction are the quality of our educational programs and coverage of state and regional issues. I am pleased that our efforts in these areas are providing value to our members.

Though the trend in satisfaction for NMHFMA over the last few years has been positive, we want to exceed the goal that national has set for chapters across the country. Based on your responses, two main areas present the greatest opportunity for improvement: increased coverage of local and state issues and greater offerings in the regional areas outside of Albuquerque.

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Our commitment to you is to take this feedback and translate it into action. As we begin to publicize our spring educational events, look for increased focus on these areas. As you begin your new year setting goals for yourselves and your organizations, our goal is that NMHFMA will be your resource of choice in providing up to date industry information on local healthcare reform and financial management solutions.

Sincerely,

Steve Figge

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Community Hospital Project Poker: How to Play a Winning Hand

Let's face it, community hospitals. When playing the financing game, the cards aren't exactly stacked in your favor.

Credit risks are to you like egos are to Washington politicians; they're pervasive. Losing a physician or your town's major employer can choke off your revenue base. And if you have any notable debt on your balance sheet, your leverage ratios already resemble a losing hand. And now you have the gumption to attempt to access capital to fund a major expansion, renovation or replacement facility?

Then be prepared for today's lending world to give you the cold shoulder, making your project feel more risky than financing ice sculptures in Arizona. To parody Sen. Stuart Smalley, "You're small, you're risky, and doggone it, people don't like you!" The investment-grade health system an hour down the road has a full house, while the high card you're left holding is a six of clubs.

You're Playing Tougher Odds

Despite the countless risks with which the capital markets' brush will paint you, it's no secret that many community hospitals have been able to reinvest and reposition themselves over the last decade. From leveraging the easy credit of 2005-2007, taking advantage of record low interest rates or, for critical access hospitals (CAHs), benefiting from a saving grace called Medicare cost-based reimbursement, many of your peers have found ways to refresh their physical plants in the 21st century.

However, today is different for a couple reasons. First, some projects that were financed were simply bad deals. Take a \$40-million-debt offering for a replacement

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CAH in the Midwest that had less than \$15 million of net patient service revenue. Are any of us surprised that offering defaulted within three years of being funded? No, and the architects, bankers and attorneys on that deal are probably not surprised by the result either. But the current market will try to guard against making that same mistake again.

Second, nonprofit health-care providers have recently been lumped in with other municipal, tax-dependent credits. At a time when historic state and federal budget deficits have coupled with an overall miserable economy, these municipal credits, including hospitals, have all taken a hit. So given this challenged hand that lacks any face cards, how can your community hospital deal still get done?

Adopting a Proper Poker Face

First, a community hospital can introduce a teammate into the game by seeking a financial partner. This usually means it will be purchased, either gradually by affiliation or immediately. That decision changes the community's control of the hospital's operations and strategic future. It also impacts the hospital's credit profile — more than likely for the better.

But if a hospital decides to take on the capital markets solo, leadership needs to remember to put on a proper poker face by adopting the right attitudes:

* Humility — A high-school buddy had the phrase "Humble Thyself" penned on his book bag. That proverbial directive should be a mantra for any community hospital seeking capital today. Of course, the hospital leadership team needs to be confident about its ability to execute its project and service the proposed debt. However, the leadership team must recognize that financial institutions and investors, for right or for wrong (and whether they tell it to your face or not), will probably not view your town as special. Therefore, you may not be able to build as large of a facility as the neighboring community hospital that is part of a system. And you may not be able to finance as much of the project as you would like through debt. Hospital leadership needs to keep that perspective in mind before trying to build a monument to its architect, CEO or board chair.

* Flexible — Your deal will not be a straight forward, uneventful experience, no matter what the investment banker, commercial banker or financial advisor tells you to win your business. The financing of your project will likely be more difficult than the architectural-design or market-feasibility processes. Therefore, it is absolutely critical that hospital leadership and its project team remain flexible. Multi-tracking financing options (pursuing multiple funding options simultaneously) are important and hospital leadership needs to be open to amending the project scope as it receives project criticism and feedback from different sources of capital. Listen to what potential capital market participants are telling you; their perspectives could be extremely valuable.

* Manageable — You must be able to afford your project. Historical cash flow should be greater than one times projected debt service. Cash to debt should quickly trend towards 100% after stabilization, and outstanding debt should not be greater than four times EBIDA (earnings before interest, depreciation and amortization) if avoidable. After all, this isn't Field of Dreams; it's Field of Reality. So when you "build it", they "may not come." Also, having a for-profit developer fund and build your campus' medical office building will have a cost, which often will be more expensive than if the hospital funded the project on its own. Keep in mind that the only difference will be that the cost of capital is taxable (hospital lease payment is greater than for-profit developer's taxable borrowing cost) rather than tax-exempt.

* A-Team — I'm not talking about telling investors and banks that you will "pity the fool" that doesn't buy your bonds. I'm talking about making sure that you have an A-rated project team. Your investment banker, bond counsel, accountant, architect and general contractor need to be proven, patient and creative. The team members need to be proven by having done similar financings for other low- or noninvestment

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-grade hospitals. Tell the potential project participant who rolls out their resume highlighting a "\$250-million project for AA-rated system" to take a hike. Your project will be way too difficult for them. And the project team, including the management team, must be patient. Again, this isn't a rubber stamped A-rated hospital deal where the investment banker's biggest question is how big their firm's logo should be on the Official Statement. No, your project team will have to answer complex questions and make difficult decisions. And finally, your team must be creative. You may leverage a Federal Home Loan Bank letter of credit to wrap around a community bank syndicate's letter of credit. Or you may issue FHA 242 mortgage-insured debt in the form of taxable GNMA securities in order to access AAA rates and minimize negative carry. No matter how your deal gets done, it will certainly take some creativity and your project team needs to embrace it.

So here's the house's advice: as a community hospital, you'll never have a royal flush. But if you plan correctly and have the appropriate attitude towards your project and the funding process, you can throw down a respectable hand and get your deal done.

Reprinted with permission from "The Capital Issue" at www.lancasterpollard.com. Steve Kennedy is a Senior Vice President with Lancaster Pollard, a leading provider of debt financing for hospitals nationwide. He can be reached at (614) 224-8800 or skennedy@lancasterpollard.com.

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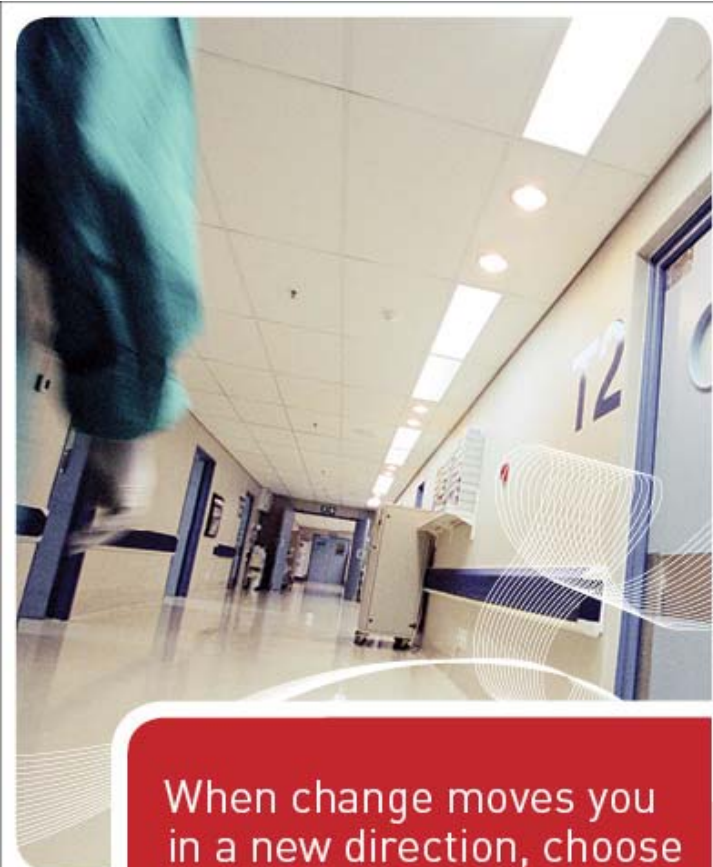
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Press Release: NM Medicaid Issues \$11.7 Million in Electronic Health Records (EHR) Incentive Program Payments - January 23, 2012.

Successful Response to Technology Aimed at Improving Patient Care
Santa Fe, NM - Healthcare providers across the state are finding something extra in their bank accounts as the New Mexico Medicaid Electronic Health Records (EHR) Incentive Program began issuing incentive payments to individual practitioners and hospitals that successfully attested to the adoption, implementation or upgrade (AIU)

of certified EHR technology. With the goal of improving the quality of patient care, hospitals and health care professionals will use the technology to collect data and meet meaningful use objectives and clinical measures established by the Centers for Medicare and Medicaid Services (CMS).

Eleven hospitals and 178 eligible professionals successfully attested to AIU of certified electronic health records technology, resulting in a total of \$11,704,136.62 in federal dollars being issued through the New Mexico Medicaid EHR Incentive Program. In this first round of payments through the end of December 2011, many eligible professionals opted to assign their payments to their clinic or group practice. Payments were dispersed as far north as Raton, Farmington and Taos, east to Santa Rosa, Clovis and Portales, south to Hobbs and Las Cruces and west to Deming, Lordsburg and Silver City, with Los Alamos, Espanola, Santa Fe and Albuquerque in between.

The EHR Incentive Program provides funding support to certain Medicaid health professionals and hospitals for the adoption and meaningful use of certified EHR technology. The money for the incentive payments is provided by the federal government, but the program is administered by the New Mexico Human Services Department (HSD), Medical Assistance Division.

"We've had a phenomenal response to the program," said Julie Weinberg, HSD Medical Assistance Division Director. "Another 500 eligible professionals and eligible hospitals are in the process of registering, attesting, or having their eligibility information validated by program staff. I'm pleased to see that Medicaid providers from all around the state are taking advantage of the program."

The New Mexico Medicaid EHR Incentive Program spans the years 2011 to 2021. Within that timeframe, eligible professionals may be paid up to \$63,750 over a six-year period, with a first-year incentive payment of \$21,250 for the adoption, implementation, or upgrade (AIU) of certified EHR technology and \$8,500 in each of the subsequent program years for the meaningful use of the technology.

Incentives for eligible hospitals are calculated through a formula created by CMS and are paid over a three year period for AIU of certified EHR technology in program year one, and for meaningful use of the technology in program years two and three.

As much as \$300 million could eventually be distributed to participating providers over the course of the program.

"The New Mexico Medicaid EHR Incentive Program is an integral part of state and federal efforts to improve the quality, efficiency and safety of healthcare through the use of health information technology and the exchange of information," said Sidonie Squier, Human Services Department Secretary, "while maintaining patient privacy and security."

"This program helps get the needed EHR technology into the hands of our Medicaid health care professionals," added Squier.

Medicaid providers will use the technology to capture data and meet meaningful use objectives and clinical quality measures established by CMS with the goal of advancing clinical processes and improving patient outcomes. Expected results include accurate and complete patient health information, improved patient care coordination and active engagement by patients in their own healthcare.

Two of the objectives for eligible professionals are providing patients with an electronic copy of their health information, including diagnostic test results, problem lists, medication lists, and medication allergies; and providing clinical summaries for patients for each office visit.

Eligible professionals for the program are physicians, dentists, pediatricians, nurse

practitioners, and certified midwives. Also eligible are physician assistants practicing predominantly in federally qualified health centers (FQHC) or rural health clinics (RHC) that are led by a physician assistant. Eligible hospitals are acute care hospitals, including critical access and cancer hospitals.

Health care professionals must meet certain criteria to participate in the program, including minimum Medicaid patient volume thresholds. The criteria vary for certain provider categories, such as for hospitals and pediatricians.

Medicaid providers interested in registering for the EHR Incentive Program should visit New Mexico's her Incentive Program outreach page at <http://nm.ara incentive.com>

For more information about the program, visit the HSD's Medical Assistance Division website at <http://www.hsd.state.nm.us/mad/MedicaidEHRIncentiveProgram.html>

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Welcome to the Members who have Recently Joined the New Mexico Chapter

New Members

- **Carol M. Wilkens**, Tax Manager
Burt & Company CPAs, LLC
- **Lynda Davis**, Financial Analyst
Nor Lea General Hospital
- **Nan Evans**, Controller
Lovelace Health Plan
- **Veronica Galaviz**, Financial Analyst
Lovelace Women's Hospital
- **Farley H. Vener**, President
Hinkle + Landers, PC
- **Julie Alliman**, Assistant Controller
Lovelace Medical Center
- **William F. Beckelhimer**, Controller
Lovelace Health System
- **Sarah Vogel**, Data Analyst
Lovelace Women's Hospital

Transfers

- **Dennis C. Empey**, CPA, Chief Financial Officer
Christus St. Vincent Regional Medical Center
- **June Durnan**, PFS Director
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Making the Grade: Choosing the Right Rating Agency

You've decided to fund your next capital project with a rated bond issue. Your next step is to decide which credit rating agency (CRA) to use. Now the dilemma: how do you pick the one that will get you the lowest cost of capital?

Role of Credit Ratings

Credit ratings, essentially opinions about credit risk issued by CRAs, play a role in enabling businesses, governments, nonprofits and other entities to raise money in the capital markets through bond issuances. "Having a rating is similar to a compass," said Tom Woolsey, senior vice president at Lancaster Pollard and manager of its trading desk. "As an investor, a rating gives you a direction to your purchase and a focus point in the credit evaluation process. It allows you to consider ranges of rates within each rating category, which are used to differentiate between multiple types of issuances, such as hospitals, senior living and affordable housing."

From an investment perspective, there are generally more buyers interested in rated debt than nonrated debt; therefore, having a rated issue increases the universe of prospective investors. On the whole, a rated product finds an easier path to portfolios than a nonrated one does, according to Woolsey.

The Field: Fitch, Moody's and S&P

However, finding a CRA that will give you the best rating for your issue involves research and serious consideration by you and your investment banker. The three largest credit agencies in the United States are Standard & Poor's (commonly called S&P), Moody's Investor Service and Fitch Ratings. "The Big Three," as they are called, have about 95% of the world-market share for ratings. Each has its own

criteria and methodology in measuring credit worthiness. In forming their opinions of credit risk, these credit agencies primarily use analysts or mathematical models or a combination of the two.

Moody's uses a different rating system for long-term and short-term debt from S&P and Fitch. The systems are similar in that both range from highest credit quality on one end to default on the other, with different degrees for each rating.

Long-term Bond Rating		Grade	Risk
Moody's	S&P/ Fitch		
Aaa	AAA	Investment	Highest Quality
Aa	AA	Investment	High Quality
A	A	Investment	Strong
Baa	BBB	Investment	Medium Grade
Ba, B	BB, B	Noninvestment	Speculative
Caa/Ca/C	CCC/CC/C	Noninvestment	Highly Speculative
C	D	Noninvestment	In Default

Choosing a CRA

There are several overall and sector-specific factors to consider when selecting which one of "The Big Three" to rate a bond issue. Generally, a borrower's prior experience with the rating process, internal readiness to be rated and whether there are other borrowers in the local market that have similarly rated bond issuances play a role in the decision-making process. When evaluating the credit agencies, you and your investment banker should consider the following:

- * Fees — Fitch, Moody's and S&P use the issuer-pay model where fees are determined in part by the service completed and the par amount of the debt issuance. Each of the agencies charges for the initial full rating and an annual fee for surveillance of the rating for the duration of the debt.
- * Timeline — Typically, the rating process from initial meeting with a credit agency to public release of the rating takes about 90 days. However, as with any vendor, get a firm estimate of the time involved from the rating agency you're considering.
- * Recourse — Although credit ratings are final when made public, each CRA has its own philosophy or approach to customer satisfaction if an issuer isn't satisfied with a rating. Moody's states, "Ratings are never 'final' when they are issued as various internal and external circumstances can cause us to re-evaluate at any time." Fitch explains it has a "very clear rating and review process, which includes an opportunity for a borrower to request additional review of any rating decision..." S&P considers the rating process voluntary. It holds that "the client decides whether or not to make the rating public."
- * "Sell-ability" — When considering a CRA to rate a bond issue, borrowers should take into account the size of each CRA's bond-rating portfolio for their industry as bond investors tend to favor the rating agency with the most investment-grade bonds for that sector.
- * Approach — Borrowers should review and understand the criteria that each CRA uses when rating a bond issuance. Generally, each CRA has sector-specific criteria which identify key qualitative and quantitative credit factors guide the rating decision. These will be discussed further for each sector below.

Finally, let's take a look at each CRA by sector — hospitals and health systems, senior living and affordable housing — focusing on the number of rated bond issues in their portfolios at the time of publication and the criteria each one uses in rating bonds.

Hospitals and Health Systems:

* Fitch has ratings on revenue-supported 230 hospitals and health systems, including 129 stand-alone hospitals and 101 health systems. The criteria for nonprofit healthcare include three categories of analytical focus: governance and management, operating profile and financial profile. Hospitals are rated on revenue-supported master criteria, unless a general obligation bond has been passed then tax-supported criteria apply.

* Moody's rates about 1,200 hospitals and health systems (no breakdown available). Its analysis focuses on market position, governance and management, operating performance, balance sheet and capital plan and covenants and legal framework.

* S&P provides credit ratings to 410 stand-alone hospitals and 140 health systems. Criteria are divided into the Enterprise Profile, which looks at demographics, business position, management, payor profits, demand, medical staff and governance, and the Financial Profile, which examines an organization's financial policies and performance, liquidity, financial flexibility, debt and liability. After evaluating the credit quality of hospital operations, S&P will assess the strength of the supporting tax base.

Senior Living:

* Fitch provides ratings for 74 continuing care retirement communities (CCRCs) and four nursing homes, which are evaluated using their respective sector-specific criteria. The analytical focus is the same as hospitals.

* Moody's has only one rated senior-living provider at this time.

* S&P rates 70 CRCCs. The criteria are the same as hospitals.

Affordable Housing:

* Fitch rates four general obligation housing agencies, each with several rated indentures within them. Rating criteria for state housing finance agencies (HFAs) and single-family mortgage sector include: asset quality and loss mitigation, financial resources and management capabilities. The criteria for pooled multifamily housing bonds focus on pool composition and performance, issuer management of the pool, program financial strength and bond/legal structure.

* Moody's covers HFAs and nearly 1,000 single-family pooled and multifamily projects. HFAs are evaluated by: financial position, portfolio performance and composition, management and general underwriting criteria. Related categories like variable-rate demand bonds and multifamily housing bonds secured by Fannie Mae and Freddie Mac also are relevant.

* S&P maintains ratings on 66 affordable real-estate transactions and 29 bond issues that benefit from Section 8 project-based subsidies. S&P evaluates a number of factors when determining the credit strength of an affordable real estate of Section 8 property. While debt service coverage is a key component, they also take into account past financial performance of the property, the surrounding real estate market, the strength of the owner and the management team and the asset quality of the property.

Credit Ratings in Action

Lancaster Pollard was engaged by a hospital district in the Southwest to provide financing for a replacement critical access hospital (CAH). The district, which provides the CAH with operating and maintenance support, passed a general

obligation bond with an 82% approval rating. It would have been a stretch to attain an investment-grade rating with the CAH's revenues alone, so we reviewed past hospital ratings by two of the rating agencies to determine which CRA's methodology would best fit our client's situation and provide the most advantageous rating. Through the analysis, it became clear that one CRA would base its rating on the district's taxing power and put less emphasis on the hospital's operations, whereas the other CRA would base its rating on the hospital's revenue and then make adjustments based on tax support. Using the latter CRA would have resulted in a lower rating. We recommended the former and the hospital attained a BBB+ rating.

It's really this simple: being familiar with how CRAs rate bond issues will help you be successful in obtaining the highest possible rating and lowest cost of capital for your project.

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Upcoming Events

NMHFMA's Program Committee is putting together two great educational programs this spring. The first will be a Legislative update. It will be held in late March at the NM Hospital Association building in Albuquerque. Please stay tuned for more details on the agenda and registration. The second offering will be a joint conference with the Health Information Management Association at the Hyatt Regency hotel in Albuquerque. This conference will be held on April 12 and 13. More details on this conference will be available soon as well, so please mark your calendars and plan to join us at these two events!

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Recap: Surviving Healthcare - 4th Joint Conference with MGMA

Right before Thanksgiving, NMHFMA partnered with MGMA again to offer the members of both associations a helping of high-value professional education. There were a number of breakout sessions offered by both associations and several key note speakers as well. Here's a quick recap of the conference:

JJ Parsons, Vice President of Performance Excellence at Presbyterian Healthcare

Services opened the conference with an engaging talk entitled Making \$'s and Sense About Linking Quality and Payment. JJ discussed how, with more public reporting of data, increased consumer use of social media (consumers shopping for healthcare), and changes to governmental reimbursement (i.e. payment for outcomes), the future is moving toward linking clinical and service quality to payment.



JJ Parsons, Vice President of Performance Excellence at Presbyterian Healthcare Services kicks off the fourth joint MGMA and HFMA conference.



Jennifer Martin, Government Affairs Representative for Medical Group Management Association (MGMA) gave the MGMA Washington Update on the Deficit Committee / Sustainable Growth Rate. She covered the resulting political landscape, and its potential impact on longer-term payment reforms, the final 2012 Medicare Physician Fee Schedule, Federal incentives, and Administrative Simplification and Compliance.

Jennifer Martin, Government Affairs Representative for MGMA gives a Washington update.

Chris Becraft, President of Collection Service Bureau Inc., gave a talk on Collection Agency Selection and Performance Analysis. He discussed how to evaluate potential agency partners, create a benchmarking environment, understand what to measure, and know how to identify common variables that will skew performance.



Chris Becraft, President of Collection Service Bureau Inc., gives tips on evaluating potential collection agencies.

Chris Tyhurst, CPA, Principal, and Halie Garcia, CPA, Audit and Consulting Accountant of REDW LLC gave a joint presentation on Accounting and Financial Reporting Changes: What Your Healthcare Organization Needs to Know. Their topics included: Recently Issued ASUs, FASB/IASB Exposure Draft on Leases, International Financial Reporting Standards, Status of AICPA Healthcare Guide, FASB Re-visiting Going Concern, GASB Update, and Private Company Financial Reporting.



Chris Tyhurst and Halie Garcia from REDW, LLC describe a number of recent accounting and financial reporting changes.

Chris Tyhurst and Halie Garcia from REDW, LLC describe a number of recent accounting and financial reporting changes.

Cheryl Storey, CPA and Health Care Partner with Moss Adams, LLP gave a Medicare Regulatory Update. On the agenda were inpatient related issues which included DRG updates, low volume adjustments, low per capita counties, Medicare cost per beneficiary, and proposed readmission policies. Cheryl also discussed cost report related items, specifically disproportionate share and current wage index issues. She finished up her talk with a brief discussion on three Day DRG Bundling Rule Changes, the OPPS final rule and the 2012 OIG work plan.



Cheryl Storey, Health Care Partner with Moss Adams, LLP gives a Medicare regulatory update.

[Link to conference materials on NMHFMA website](#)

NMHFMA wants to thank the folks at MGMA for working with us on the conference. And we'd especially like to thank the conference sponsors, exhibitors, presenters and attendees for making the conference happen!

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Call for Input and Participation

The Newsletter Committee for the NM Chapter of HFMA invites you to provide your input and feedback on what you like about the newsletter and what you'd like to see changed. Are there topics about which you'd like to see articles? Are you aware of members or health care organizations in New Mexico that deserve recognition? We'd love to hear about them! We also welcome your participation in chapter activities - if you are interested in helping out with the quarterly newsletter or other chapter activities, please let us know. You can e-mail us at: nmhfma@scitd.biz.

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NM HFMA P&L Summary June 1, 2011 through December 31, 2011

6/1/11 through 12/31/11			
	<u>YTD Actual</u>	<u>Budget</u>	<u>Variance</u>
REVENUE			
Total Program	41,412.19	25,500	15,912.19
Total Other	12,748.40	29,000	(16,251.60)
Total Revenue	54,160.59	54,500	(339.41)
EXPENSES			
Total Program	38,091.64	21,000	(17,091.64)
Total Leadership Conf	6,045.65	11,000	4,954.35
Total Other	5,226.96	15,100	9,873.04
Total Expenses	49,364.25	47,100	(2,264.25)
NET INCOME/(LOSS)	4,796.34	7,400	(2,603.66)

New Mexico Chapter of HFMA
P.O. Box 9723
Albuquerque, NM 87119

email: nmhfma@sc ltd.biz

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