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July/2011

## President's Message

As I begin my first official President's Message, I must first pause to thank Chris Tyhurst for his dedication and leadership as President during the past year. I have followed Chris through several officer ranks and he has always continued to raise the bar in terms of what we hope to achieve. I am truly honored to have been selected to lead the NM Chapter for the 2011-12 year and eager to begin working to address the evolving needs of our members as healthcare proceeds toward what will certainly be the most relevant and pivotal times in the history of healthcare.



HFMA's theme this year is "Believe to Achieve." Our National Chair, Greg Adams, explained at ANI this past June that "although it sometimes feels like the wrong time to be working in health care, now is the right time for those who recognize that where there is major change, there are also major-league opportunities." He further explained that "by choosing to believe that together, we can solve the problems that have challenged our industry for so long, we can find a place for ourselves and our organizations in the new environment and help shape the future of health care."

One way that NMHFMA honors this message is through our collaborative partnerships with other local associations on educational programs. Our chapter is dedicated to providing locally based, quality educational events at an affordable price to ensure that our members have opportunities to learn about changes in the industry and talk with other healthcare professionals about what solutions exist to address the challenges we are faced with through reform legislation. This fall we are proud to host our annual event with MGMA on November 17-18th at the Sheraton Uptown in Albuquerque. Please mark your calendars for this important event.

Since we are a volunteer organization, our success depends on member involvement. If you are interested in continuing your education, learning "best practices" in your field, and staying connected to other professionals in the industry, New Mexico HFMA is here to provide you with those resources. Please feel free to contact me or one of the other chapter officers directly for information on how you can get involved in our chapter. I look forward to seeing you at our upcoming events.

Sincerely,

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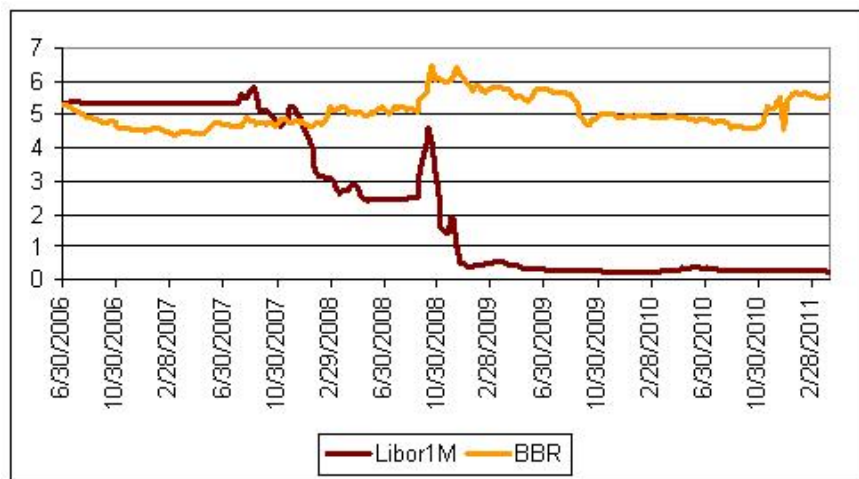
Negative arbitrage (*Infitialis arbitari*) has historically been a manageable nuisance to hospitals considering tax-exempt bonds for funding construction projects - comparable, perhaps, to the geese congregating around the hospital campus' pond. In recent years, however, the negative arbitrage budget line item has swelled. As a result, negative arbitrage has devoured precious funds for improvements, and in some cases made projects infeasible. It's as if those geese (*at least the children enjoy them...*) have transformed into pre-historic pterodactyls (*hide the children!*). For some hospitals, the cost of negative arbitrage has become a bad-monster-movie metaphor. Why has negative arbitrage become so costly, when will its effect dissipate, and what mitigation strategies currently exist?

**What is Negative Arbitrage?**

Arbitrage, with respect to tax-exempt debt, is the difference between the interest rate a borrower pays on its debt and the interest rate the borrower can achieve by investing yet-to-be-spent debt proceeds.

In the mid-2000s, tax-exempt borrowers had the potential to make a profit (or positive arbitrage) on unspent bond funds. Currently, however, hospital borrowers must pay out more to investors than they take in from investments. This extra capitalized interest is negative arbitrage.

Figure 1



The U.S. Federal Reserve's efforts to stimulate the economy, by taking short-term variable interest rates to near zero, has created a wide spread between the interest rate paid by a tax-exempt borrower (indicated in Figure 1 by the Bond Buyer Revenue Index, BBR) and that earned on investments (indicated by one-month Libor, a short-term interest rate benchmark). Hospitals may be borrowing at interest rates of 7% or higher, while bond proceeds invested during construction are earning almost nothing. As Figure 2 shows, the cost for a project can grow to financially unacceptable levels as interest rates and project size rise.

Figure 2

	Rate 1	Rate 2	Rate 3
Hospital's interest rate	5.00%	6.00%	7.00%
Interest rate earned on unspent bond funds	0.25%	0.25%	0.25%
Difference	4.75%	5.75%	6.75%
Annual negative arbitrage per \$1 million	\$47,500	\$57,500	\$67,500

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**September  
28-29**

**NMHA Annual  
Meeting and  
Assembly**

**September 28:  
Pre-Conference  
Workshop**

**September 29: Two  
NM HFMA  
Sponsored Sessions  
in the morning**

When will this large negative gap close? The economy must strengthen and then, hopefully, the Federal Reserve will be able to reduce its support and increase short-term interest rates. Based on historical precedent it will take several years for short-term taxable rates to reach the levels of tax-exempt fixed interest rates. Fortunately, there are several strategies for hospitals to consider.

#### **Draw-down Funding Structures**

One way to eliminate negative arbitrage is to ensure yet-to-be-spent project funds do not reside with a bond trustee. This can be accomplished by utilizing a draw-down funding structure. Similar to a home construction loan in functionality, borrowers pay interest only on funds that have been spent for project purposes. Two draw-down funding structures hospitals can utilize are private placements with commercial banks and FHA/HUD Section 242 insured taxable securities.

#### **Private Placements**

Private placements let hospitals enter into loan agreements directly with commercial banks. The loan agreement may be with a single bank, or multiple banks via a syndicate arrangement. Commercial banks are familiar with draw-down bonds and generally offer more flexible structuring than trust indentures.

Private placements are often done as taxable transactions, but the interest rate may still be tax-exempt if the transaction is structured through a conduit issuer, and bond counsel provides the necessary tax-exempt opinion. Whether these additional expenses are justified is determined by cost/benefit analysis. A Lancaster Pollard client developing a \$14.5 million addition in Kansas recently found that the tax-exempt private placement draw-down structure allowed them to avoid more than \$1 million in negative arbitrage.

#### **Federally Insured Taxable Securities**

Federally insured taxable securities work well for projects that are too big for commercial banks, or where a fixed interest rate is desired. The U.S. Department of Housing and Urban Development has been funding hospital projects through its Section 242 mortgage insurance program since 1968. The current loan portfolio includes health systems, sole community providers and critical access hospitals.

While the program can insure either tax-exempt bonds or taxable securities, only the taxable option allows for a draw-down structure. As a result, many HUD 242 borrowers, whether \$20 million critical access hospitals or \$200 million urban medical centers, are currently electing the taxable structure. Recent Lancaster Pollard clients avoided approximately \$2 million and \$3.3 million of negative arbitrage, respectively, on \$25.9 million and \$34 million projects.

#### **Mitigating Negative Arbitrage**

For a variety of reasons, a hospital may not be able to access an affordable financing option that permits a draw-down funding structure. In these cases, hospitals have several options to mitigate negative arbitrage:

- 1) Let the funds reside with the trustee in a money market fund. Under current conditions, however, money market funds produce almost no interest income.
- 2) Enter into a GIC, or Guaranteed Investment Certificate. This long-term savings option allows hospitals to receive a fixed interest rate payment and make withdrawals as needed. Rates, however, are fixed once they are set, and GICs offer far fewer options than they did prior to the market meltdown.
- 3) Hire an investment advisor to actively manage the funds.

Active management by an investment advisor means a hospital can build a customized

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17 & 18**

**NM HFMA and  
MGMA New  
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Additional Details  
Soon!

investment strategy around the projected construction schedule. Funds that will be needed early in the process can be invested in short-term, highly liquid assets, while funds that will not be needed until farther along in the process can take advantage of longer-term investments and the potential for higher short-term interest rates as the economy improves.

As with the popularity of the horror movie genre, the headaches associated with negative arbitrage shall eventually pass. Unfortunately, unlike a summer movie season, the current negative arbitrage cycle may be around for several more years. In the meantime, be sure to work with an experienced investment bank capable of providing independent advice on all funding options.

Bill Wilson

*Reprinted with permission from "The Capital Issue" at [www.lancasterpollard.com](http://www.lancasterpollard.com). Bill Wilson is a Senior Vice President with Lancaster Pollard, a leading provider of debt financing for hospitals nationwide. He can be reached at (785) 841-3700 or [bwilson@lancasterpollard.com](mailto:bwilson@lancasterpollard.com).*

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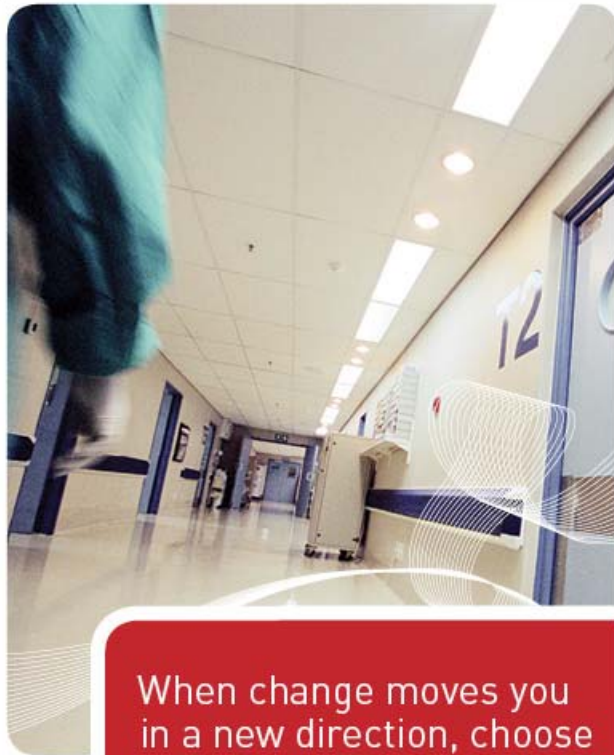
**NM Chapter Collects Two Awards at ANI**

Past chapter President, Chris Tyhurst, attended HFMA's Annual National Institute in Orlando, Florida last month and accepted two awards on behalf of the chapter. We earned a Gold Award for membership growth and retention and a Silver Award for certification. Thanks goes out to Renee Ennis and her membership committee, as well as all our members for their continued support of the chapter!



*Chris Tyhurst (center) with Debi Kuchka-Craig, 2010/11 Chair  
and Greg Adams, 2011/12 Chair at ANI*

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

### New Members

- **Susan T. Anderson**  
Senior Accountant
- **Sheila Bova**, Director of Accounting  
Lovelace Health Systems
- **Kathleen Bustos**  
Presbyterian Healthcare Services
- **Kelly Garcia**, Operations Manager

Presbyterian Healthcare Services

- **Cynthia S. Gilbert**  
Katherine W. Hall PC
- **Todd W. Mason**, Director of Finance  
CHRISTUS St. Vincent Regional Medical Center
- **Orlando L. Moreno**, Senior Accountant  
REDW, LLC
- **William E. Sharer**, President  
CBF Services

#### Transfers

- **Gina J. Anderson**, Chief Finance Officer  
Lovelace Medical Center

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The advertisement features a photograph of four test tubes on a white rack. The first, second, and fourth tubes contain blue liquid. The third tube contains a US one-dollar bill. To the right of the image, the text reads: "HEALTHCARE FINANCIAL Services" in a serif font, with "Services" in italics. Below this is the slogan "It's What We Do, and we're dedicated to doing it well." The REDW LLC logo, which includes a circular emblem with the letters "C" and "A", is positioned to the left of the company name "REDW LLC" and the tagline "The Rogoff Firm". At the bottom right, the website "REDW.COM" and phone number "505.998.3200" are listed, along with the text "CERTIFIED PUBLIC ACCOUNTANTS, BUSINESS & FINANCIAL ADVISORS".

### Funding Issues of the Exchanges and Outreach

At present, 26 states are involved in Florida et al v. United States Department of Health and Human Services, which challenges the Patient Protection and Affordable Care Act (PPACA) on the grounds that the act constitutes a federal mandate forcing individuals to purchase health insurance in violation of the Commerce Clause of Article I of the Constitution. On February 7, 2011, 21 Governors sent a letter to Health and Human Services (HHS) Secretary Kathleen Sebelius requesting complete flexibility and control over the structure and operation of the exchanges to determine what best benefits their citizens. Secretary Sebelius and the HHS responded claiming the PPACA already offers what the Governors were requesting. The legislation also makes it difficult for Governors to avoid their exchange-related responsibilities. If states fail to create an exchange accepted by HHS in time, the federal government will intervene to establish and operate an exchange of its own as outlined by the PPACA.

Even if the majority of states were not fighting the PPACA, they may have to refrain from making any significant progress on the exchanges until state officials address their looming budget deficits. According to the Center on Budget and Policy Priorities, "the upcoming fiscal year is shaping up as one of states' most difficult budget years on record. Thus far, some 44 states and the District of Columbia are projecting budget

shortfalls totaling \$112 billion for Fiscal Year 2012". With budget constraints being a major hurdle to the creation and implementation of health insurance exchanges (HIE), Secretary Sebelius recently stated that the federal government plans to give grants to states and the District of Columbia to help establish them. On the other hand, some states have put the wheels in motion to remove the Federal money from their budgets.

However, states will have many options in creating the exchanges, or can choose not to create them at all. According to the National Academy of Social Insurance, states will have five avenues in which to structure the exchanges: creating or using a government agency; a not-for-profit entity created by the state; a multi-state exchange; a sub-state exchange serving geographical areas; or allow the federal government to setup and run the exchange. While it might be difficult to imagine the insurance exchanges being built with legal and budget battles occurring nationwide, the multiple options indicate that ~ unless the bill is overturned ~ the insurance exchanges are likely to be formed.

The Medicaid piece may be the most complicated program to automate, and the insurance exchanges will need to coordinate with the Medicaid program to achieve the goals of the PPACA. In order to be as valuable to the citizens as possible and give them the most effective way to find the medical coverage they need, the health insurance exchanges should be overly inclusive giving people the highest possible number of administrator and program options. If the HIE is not a "one-stop-shop" for citizens to search for insurance and public programs they are eligible to enroll in, then it will not have achieved its purpose. A single selection tool must also be capable of combining the insurance exchanges with Medicaid eligibility and enrollment screening. This tool could include state and local government programs, as well as charity care programs, for those eligible for insurance but may still need assistance on past medical bills. Perhaps the biggest question related to health insurance exchanges is whether the states will be able to handle the outreach necessary to get newly eligible people enrolled and meet the goals of the PPACA.

With Medicaid expanding to cover virtually all individuals under 65 with income levels up to 133% of the Federal Poverty Line (FPL), the Congressional Budget Office (CBO) estimates that by 2019 the PPACA will enroll 16 million additional currently uninsured people in the Medicaid program and 24 million more Americans will be enrolled in a health insurance option; 162 million will continue to receive insurance through the workplace. While this number appears to show that the PPACA will cover a large chunk of the estimated 40 million currently uninsured in the country, one needs to take into consideration that only 83% of people presently eligible under minimum Medicaid program limits are actually enrolled. That means an astounding 17% of Medicaid eligible people before the PPACA's expansion of the program did not enroll.

The current outreach that is necessary to maximize enrollment has clearly been insufficient. The Medicaid population is not static: someone who is not eligible today may be eligible tomorrow. This makes constant outreach and education necessary to assist those eligible with the enrollment process. Considering the budget woes of states, it is hard to imagine an effective outreach program being developed to assist not only newly eligible people, but the current people who are eligible that never enrolled. By 2014, states will have to implement an effective automated HIE that will incorporate both public assistance programs and various insurance options. However, uninsured patients will continue to enter hospitals as current outreach efforts fall short and future outreach efforts are at the mercy of state budgets. Those hospitals that become more proficient at Medicaid screening and have the ability to assist and educate patients in the enrollment processes of available programs will be in the best position to provide assistance to the uninsured and to ensure the services they provide will be reimbursed.

Christopher Thunder and Ryan Brebner

Used with permission from R&B Solutions. Christopher Thunder is a policy analyst and writer for R&B Solutions, a Medicaid Advocacy company headquartered in Waukegan, Illinois. Ryan Brebner is Manager of Business Development for R&B Solutions, and is responsible for leading the company's sales and marketing. For further information, call 847-887-8514 or e-mail Ryan at [rbrebner@randbsolutions.net](mailto:rbrebner@randbsolutions.net).

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## **NM Hospital Association Annual Meeting and Assembly Coming in September**

It's just a couple months until the NM Hospital Association's annual conference. This year's agenda looks intriguing. Once again, the NM Chapter of HFMA will be supporting the meeting by offering two break-out sessions the morning of September 29. The first will be an update on the healthcare lending market presented by Wells Fargo. Moss Adams will follow that up with an accounting update and a discussion of the NM gross receipts tax. Barbara Lorschach, Senior VP, Member Relations at the American Hospital Association, will give a Washington update during lunch. Joy Johnson Wilson, with the National Conference of State Legislators, will present a current discussion of the impact of health care reform on the states and Greg Schwem will end the day with a lighter look at the healthcare industry. [Register now](#) - we hope you can make it!

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## Grabbing the Reins of Your Self-Pay Population: While Patients and Hospitals Struggle with Debt, There is a Win-Win Solution

The term "Perfect Storm" has been used many times during the current economic downturn. It is especially true when referring to the increasing challenges patients are

facing while trying to afford healthcare.

Consider this: Employers are offering fewer benefits, which results in employees paying higher deductibles and more out-of-pocket medical expenses. Despite reduced insurance coverage, healthcare costs continue to increase, exacerbating the burden of medical expenses on the patient. The Milliman Medical Index reports that healthcare costs for a typical family of four increased 7.2 percent in 2009 to an all-time high of \$18,074.

With unemployment at a 27-year high, fewer patients have any form of health insurance, forcing more patients to use their rapidly dwindling savings to pay for the majority, if not all, of their healthcare expenses. Patients are doing their best to pay their obligations and avoid being sent to collections, however, there are fewer lenders in the market and the Credit CARD Act of 2009 has made it more difficult for most consumers to obtain credit.

Patients who are not able to meet the provider's minimum payment guidelines are being referred to collections, which in turn contributes to a deteriorating hospital-patient relationship.

The Perfect Storm shows no signs of letting up. As Health Care Reform becomes reality, insurance companies will be required to insure more people, resulting in even higher deductibles and additional strain on patients and the hospitals that will have difficulty collecting payment from the patients. A survey by AMN Healthcare revealed that approximately 70 percent of healthcare executives believe reform will hurt their facility's financial stability.

ClearBalance by CSI Financial Services reports that the volume of loans being processed has risen dramatically over the past few years while the average loan amount has dropped from approximately \$1,500 to \$850 per patient. This statistic demonstrates that the rising cost of healthcare combined with challenging economic conditions makes it difficult for patients to pay a lump sum payment of nearly any size.

While the Perfect Storm continues, the sun is beginning to shine on self-pay patients and hospitals. Healthcare providers are embracing with greater enthusiasm patient financing programs that give patients the ability to pay out-of-pocket expenses over time, which also can help reduce their bad debt and, importantly, also reduce their A/R days.

The relationship between a healthcare provider and patient is critical to the provider, the patient, and the community at large. Giving patients a financing option with greater flexibility to pay their self-pay balance will not only help preserve that relationship and improve the revenue cycle, but also increase census as patients continue to look for affordable healthcare.

Vince Koch

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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@scltd.biz](mailto:nmhfm@scltd.biz).

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NM HFMA P&L Summary June 2010 through May 2011

6/1/10 through 5/31/11

	<u>YTD Actual</u>	<u>Budget</u>	<u>Variance</u>
<b>REVENUE</b>			
Total Program	35,321.61	22,000	13,321.61
Total Other	25,688.00	19,000	6,688.00
<hr/>			
Total Revenue	61,009.61	41,000	20,009.61
<b>EXPENSES</b>			
Total Program	29,106.46	21,900	-7,206.46
Total Leadership Conf	8,049.91	7,500	-549.91
Total Other	11,053.71	10,100	-953.71
<hr/>			
Total Expenses	48,210.08	39,500	-8,710.08
<hr/>			
NET INCOME/(LOSS)	12,799.53	1,500	11,299.53

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