



The GemStatement



President's



Can you say lame duck? Only 50 days (not that I am counting) to go to the end of my term as president. I have to say that it has been a blast; I have really enjoyed representing the chapter and have gained so much from this experience. When I took this job, Luke Zarecor gave me great advice—"Just don't screw it up and you will be fine". With that said, I am looking back at this year, and am excited to report that we didn't screw it up!

Moreover, the team was able to achieve our goals of increased access to education, resources, and networking. The following is an overview of our results:

- Increased educational events and access
- Provided three web-based one-hour educational events
- Partnered with IHA to provide two one-day road shoes in Pocatello and Lewiston
- Partnered with the Washington Chapter of HFMA to provide a joint meeting in Spokane.
- Increased Membership to 172 and growing. . .
- Provided chapter survey to drive future education and outreach
- New Website redesign (tentative go-live of May 3rd)

All of these achievements are a direct result of a great team. Our volunteer board

and amazing sponsors allow for this association to provide the affordable and excellent content we are known for. I am excited about next year's leadership team and with Darci Linstrum's direction, the chapter will continue to grow and prosper upon the rich tradition of Idaho HFMA. I won't forget my time, but do look forward to being one of those past presidents who sit quietly in the back of the room! Thanks for all your support and I look forward to seeing you at the next HFMA event.



Inside this issue:

Medicaid Expansion Under Health Care Reform	2
Patient Receivable Loan Programs Finding Resurgence	3
Automated Charity Program Cuts \$1 Million	6
Educational Events Calendar	9
Short-Lived Financing Options Make Projects Feasible	10
More Hospitals to Become Eligible to Refinance	12
Chapter Leadership Reference Guide	15

Special points of interest:

- Medicaid Expansion in Healthcare Reform
- Patient Receivable Loan Program
- Financing Options
- Chapter Leadership Reference Guide
- Message from Region 10 Regional Executive

Medicaid Expansion Under Health Care Reform

By Chris Brazil, Vice President, Sales and Marketing, Outreach Services

Under the Patient Protection and Affordable Care Act, recently signed into law, Medicaid will serve as a cornerstone for expanded health care coverage. As a result of this law, the Congressional Budget Office estimates that by 2019 an additional 16 million individuals will obtain coverage through Medicaid and CHIP (Children's Health Insurance Program). Although health care reform reaches far beyond Medicaid, the purpose of this article is to highlight some of the anticipated changes to Medicaid programs. Unless otherwise noted, the changes addressed herein are intended to go into effect January 1, 2014. As regulations are implemented between now and then, we will undoubtedly see additional modifications that will effect Medicaid coverage.

Adults under 65. States will be required to cover adults under age 65 with income up to 133% of the federal poverty. This is a significant change, as many states currently do not provide Medicaid to childless adults and/or only cover parents at much lower income levels. All newly eligible adults will be guaranteed a benchmark benefit package that at least provides essential health benefits.

Children. States will be required to provide all children with family income up to 133 percent of the FPL with Medicaid, including those currently covered through separate CHIP programs. States currently must provide Medicaid to children under age six with family income up to 133 percent of the FPL and those ages six through 18 with family income up to 100 percent of the FPL (although most states provide coverage at higher income levels).

Immigrants. The new law will not change current Medicaid requirements for immigrants. States must establish a five-year waiting period for lawfully residing adults (with a state option to waive the waiting period for children and pregnant women). Undocumented immigrants will remain ineligible for Medicaid.

Existing Medicaid for Adults. While states may certainly increase Medicaid eligibility levels to 133% of the FPL before 2014, states are required to at least maintain existing Medicaid eligibility levels for adults and children in place as of March 23, 2010 until 2014. Maintenance of current eligibility levels is a condition to receipt of federal Medicaid funding.

Foster Care Children. Starting in 2014, children under age 26 who were receiving Medicaid but "aged out" of foster care will be newly eligible to continue receiving Medicaid.

Medicaid Reimbursement for Primary Care. The new law will increase Medicaid payments for primary care services provided by primary care doctors to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal funding for the cost of the increasing payment rates.

Please see our website at www.outreachservices.com for further updates regarding this legislation.

Information for this article was obtained from the Georgetown University Health Policy Institute Center for Children and Families' report on Key Medicaid, CHIP, and Low-Income Provisions in The Health Care Reform Package (updated April 2010) (<http://ccf.georgetown.edu/index/key-provisions-in-health-care-reform-package>)

Patient Receivable Loan Programs Finding Resurgence in Today's Economy

Written by Steve Chrapla-schrapla@revenuecyclepartners.com

Loan programs that provide external hospital financing for patient receivables are nothing new. There have been various approaches over the years to provide patient alternatives and options to satisfying healthcare obligations over an extended period of time. With consumerism in healthcare on the rise and patient expecting more payment options.....

there is a new equation in healthcare finance and receivable loan programs are gaining popularity again!

The current state of the US economy has placed extreme pressure on US households. The current economic recession has for maybe the first time impacted the financial health of our hospitals. Hospital CFO's have stated this has never occurred in previous recessions.

Here is the current economic reality:

- 74 year low in consumer savings rates.
- Credit markets that have dried up except for those who do not need credit.
- Highest unemployment in over 25 years.
- Trends in healthcare plan designs have increased co-pays, deductibles and out of pocket costs for consumers to an all time high.
- Uninsured population of working adults has grown significantly.
- Healthcare costs will continue to rise; the best we can expect is a slowdown in the level of increases.
- Consumerism in healthcare is generating stronger demands for customer service and payment options for hospitals.

All of these trends have resulted in hospitals extending more credit to patients for longer periods of time. This is occurring when hospitals themselves are challenged financially to provide more services for less reimbursement.

We are also seeing the role of patients, as healthcare

Healthcare expenditures. In fact, in today's challenging economy 24% of patients with large out of pocket costs stated that their current healthcare debt has caused them to seek care at an alternative facility to ensure treatments are received. For the first time we are seeing healthcare providers delaying or denying non-urgent treatments to patients with previous unpaid medical bills.

This shift to more consumerism in healthcare impacts the patient's financial obligations as follows:

- Patients control how their out of pocket costs are expended.
- Patients choose healthcare services based on their financial situation and their financial obligations.
- Patients expect to be treated as valued consumers and may not be willing to take direction from insurers or providers with respect to healthcare delivery.
- Patients are better educated regarding healthcare services.

Healthcare debt is perceived by consumers to be different than other types of debt and typical financing and collection techniques are only marginally successful. Patients are not traditional debtors as found in other industries. There have been many studies on the payment priorities of patients. Clearly, it is recognized that hospitals are last to receive payment from the patient. Here is an overview of how patients prioritize their monthly expenditures:

- Mortgage or Rent payment
- Car/Utilities/Bank loans
- Furniture/Credit card loans
- Insurance premiums
- Physician bills
- Hospital bills

With the hospital at the end of the list, how can we facilitate changing this priority?

Patient Receivable Loan Programs Finding Resurgence in Today's Economy

(Continued)

Hospitals have traditionally attempted to establish monthly payment plans to assist patients in satisfying their obligations. These plans are usually interest free and managed and monitored internally by the patient accounting staff. While these plans may be convenient for the patients they place significant burdens on the hospital. There is the obvious loss of capital while they wait for the cash flow; additionally there are extensive administrative burdens encountered when managing these payment plans. Another challenge with extended payment plans is the potential for new debt to be incurred by the patient. Unplanned future debt may impact the patient's ability to continue making monthly payments and result in short or missed payments.

Patient receivable loan programs, when properly designed, can use reprioritization of patient financial obligations. They raise the level of priority to ensure the obligations are met. In addition, loan programs can be designed to provide for immediate reimbursement to hospitals, removing the patient receivable from the hospital's balance sheet. Loan programs can provide significant benefits to cash starved hospitals as well as provide relief for patients finding themselves with few other options. Loan programs can be designed to provide funding directly to the hospital within days of the executed loan documents, while establishing manageable payment terms up to ten years, for the patient. Loan terms provide flexibility for patients seeking to minimize their monthly obligation.

So, what type of program works best?

There are two types of programs, Non-Recourse and Recourse. Each provide value, but with very specific distinctions. The Non-Recourse program removes any contingent liability from the hospital, regardless if the loan is paid or not. The Recourse program, on the other hand, provides that the hospital repay the outstanding

Standing loan balance in the event of default. This significant difference in risk sharing of the patient's loan is based on the design of the loan portfolio. Non-Recourse program funding may be impacted by the patient's credit worthiness; whereas under a Recourse program all patients can qualify since the hospital is at risk for default.

Here are the features of both Non-Recourse and Recourse Loan Programs:

Non-Recourse Loan Programs:

- Hospital receives upfront cash for loan value.
- Simple and expedient loan application and approval process.
- Loan portfolio performance does not impact hospital/no bad debt reserves required.
- Loan values will likely be discounted. Hospital will receive less than 100% of the account balance.
- Patients may be assessed an interest charge which is usually impacted by the loan discount rate.
- Patient credit worthiness may impact patient's ability to qualify.
- Inability of a patient to qualify may present challenges in implementing a comprehensive collection policy. How do you handle a patient that does not qualify for loans and are not eligible for financial assistance?
- Loans are unsecured with no personal asset at risk.
- Payment terms can be extended over many years.

Recourse Loan Programs:

- Hospital receives upfront cash for loan value.
- Simple and expedient loan application and approval process.
- Hospitals should establish a reserve for bad debt for loan portfolio defaults. National experience is between 15% to 22%.
- Loans that default should move directly to bad debt without consuming more administrative resources or expense.
- Loan valued at 100% of receivable. No discount applied and hospital receives 100% of account balance.
- Hospital guarantees loan. All patients qualify.
- With all patients qualifying for a loan the hospital

Patient Receivable Loan Programs Finding Resurgence in Today's Economy (Continued)

- Patients assessed an interest rate. Usually below current market trends.
- Community relations can improve when all patients qualify for loans.
- Patients with questionable credit rating have opportunity to improve credit history.
- Loans are unsecured with no personal assets at risk.
- Payment terms can be extended over many years.

Both types of loan programs when properly implemented can achieve desired results. It is critical however to ensure proper steps are taken to maximize the effectiveness of the programs. A well defined credit policy communicating all options available to patients is essential. Policies need to provide options for patients. Consistent support from administration as well as the medical staff is required to ensure exceptions to policies are minimized. A high touch patient sensitive model needs to be utilized in presenting the loan program. Hospital staff needs training in how to communicate the benefits of the program while presenting alternatives. In other words the loan programs need to be sold to patient. Including why the program is good for the patients describing all the benefits and presenting the alternatives to not establishing a loan.

What type of benefits can you expect?

- Increased cash flow from self pay receivables.
- Reduced bad debt expense.
- Reduced days in AR.
- Improved liquidity.
- Removes the hospital from the financing business.
- Reduced administrative costs resulting from fewer billing statements and cash posting transactions.
- Improved recovery of term payments made to a bank vs. to the hospital. Patients less likely to

miss a payment to a bank than to the hospital.

- Enhanced patient and community benefits when the hospital is viewed as providing options to assist patients with their financial obligations.

For more information on how to effectively implement a patient receivables loan program or to learn more about hospitals that have achieved improved performance through such programs contact Jeff Morgan, CHFP at Revenue Cycle Partners. 866-855-6905 or jmorgan@revenuecyclepartners.com.



Automated Charity Program Cuts \$1 Million from Uncompensated Care

By Bruce Nelson, Vice President, SearchAmerica

Touchette Regional Hospital, with campuses in Centreville and East St. Louis, Ill., offers cardiopulmonary, laboratory, radiology, physical therapy, behavioral health and obstetric services; an oncology infusion clinic; a 24-hour emergency department; and an intensive care unit. It also provides inpatient and outpatient medical and surgical services.

As a safety net facility, Touchette Regional Hospital fulfills its mission of providing care within their medically indigent population. More than half of the patients served at Touchette are on Medicaid or are self-pay customers. However, they realized that if good systems were not in place to support the charity-care policy, their mission could be taken advantage of.

“We really had to balance providing good care in our community to those who need it and aren’t able to pay for it, which is our mission, with performing a gate-keeping role to identify those who do have some type of ability to pay or have access to providers in their community,” explains John Majchrzak, CHFP, CPA, MBA and Vice President of Finance at Touchette.

As recently as two years ago, anyone who walked into the hospital asking for care would receive it, says Majchrzak. “We didn’t have a good system to verify income, and we didn’t have a good system to verify someone’s address, so it was all on your honor,” he says. “We saw a lot of patients driving over an hour, passing by several other providers and coming to our facility simply because somebody said you can get free care here.”

Administrators knew it was time for an overhaul of their frontend process, so they completely retooled their charity-care policy. To implement the new policy within an automated registration process, they teamed with SearchAmerica®, a part of Experian, which provides automated financial screening services, and Emdeon®, which provides revenue and payment cycle solutions for health care.

The revamped registration process included technologies designed to implement Touchette’s new charity-care policy and verify patient identity. Frontline personnel were trained on the new system and interpersonal skills, both of which are needed to make staff and patients comfortable with the computerized verification and eligibility system.

Registration personnel at Touchette were accustomed to doing everything manually, so it was necessary to have 30 people trained on how to use a new, automated eligibility system. “It was quite a kick-start, but I have to admit that it has made a dramatic change in our patients’ attitude, our revenue and our handling of charity,” explains Pat Niel, Admitting Director at the hospital.

The hospital worked with SearchAmerica and Emdeon to customize a system that would retrieve information from credit reporting agencies and insurance carriers so that it could automatically calculate a patient’s copay or eligibility for the hospital’s charity-care policy based on existing coverage, the size of the household, household income and address.

SearchAmerica’s service provides Touchette registrars with one of three possible responses to frontline personnel at the point of service:

- Probable — A patient qualifies for 100 percent charity
- Review — A patient qualifies to have 30 percent to 70 percent of their medical costs covered by charity care; the amount is determined after further financial information is provided by the patient to Patient Accounts
- Unlikely—A patient does not qualify for any charity care and is responsible for paying the full estimated cost of the procedure prior to receiving the service

With this information, frontline staff members know how to proceed with financial counseling of each patient even though they do not have access to a patient’s personal information, which is available only to the Patient

Automated Charity Program Cuts \$1 Million from Uncompensated Care (Continued)

Accounts department.

“There are going to be occasions when someone may have just lost their job within the week. That may not show up, but when you can be 90 percent free of all that [manual retrieving of information] and you can instantly communicate financial assistance to a patient at registration, that is excellent customer service,” Niel says. “Patients can now be qualified for charity at the time of registration. This eliminates the additional step of asking patients to return with financial documentation and be subject to a timely review process.”

“In the first six months of 2008, Touchette had about \$8.8 million in uncompensated care, and in the first six months of 2009, we had \$7.8 million, so we had \$1 million in improvement,” says Majchrzak. Even more interesting, while that improvement was occurring, the amount of charity care the hospital provided went from \$3.5 million in 2008 to \$5.6 million in 2009.

“Even though our total uncompensated care went down, our charity care has gone up, so to me this is showing that we are meeting the mission of taking care of those in our community who don’t have the ability to pay while at the same time performing a gate-keeper role for those who do have the ability or who don’t live in our community,” Majchrzak explains.

In addition to coming out ahead financially, the hospital has ample evidence that frontline personnel are much happier, according to Niel, who oversaw implementation of the new system. Employees formerly had to make multiple calls, inconvenience patients, and sometimes send patients home to retrieve pay stubs or other documentation. Now staff can verify addresses, income, insurance and charity-care eligibility via computer at the point of registration. “It provides the staff with sufficient knowledge at the time of registration to counsel the patient on their insurance eligibility and/or their charity eligibility,” Niel adds.

A Message from the Region 10 Regional Executive: Hal Prink, FHFMA

As my year as Regional Executive for Region 10 draws to a close I have been encouraged by the volunteer leaders in our Region as they have faced challenges this year on meeting their goals for the Chapter Balanced Scorecard and Davis Chapter Management System.

In my most recent conference call it appears that most will meet their education and membership goals in spite of a tough economy and healthcare tightening budgets for membership and education. They had to become creative and did with lunch and learn programs, one day programs, webinars and with the support of HFMA National participation in the Virtual HFMA Conference.

We have a Region loaded with volunteer members who are willing to go the extra mile to make it happen. The fruits of their labors will be recognized at the HFMA Annual National Institute in June 2010 in Nashville at the Chapter Presidents Dinner when many awards for excellence are given out and we expect our Region to be well represented.

In addition, I had had the opportunity to meet many of our members as I visited chapters and interacted with the Presidents and Presidents-Elect in meetings and on conference calls.

I will turn over these responsibilities to Dave Chohon from the Arizona Chapter after the LTC and know he will continue to lead our Region very effectively.

A major accomplishment we are making this year is the instituting of Region 10 Webinars which you will be hearing more about in the coming months.

Thanks for a great year and look forward to seeing many of you at the ANI in Nashville in June.

Hal Prink, FHFMA

Region 10 Executive
halprink@comcast.net





New Member Spotlight

Please join us in welcoming our newest Chapter Members!

Welcome! We look forward to seeing you at our next meeting!

Melissa Pongrac



Melissa lives in Coeur d'Alene, ID. She attends school at Gonzaga University in Spokane, WA. Melissa is majoring in accounting, and is a junior this year. She also works full time at Best Buy, and is hoping to intern for a hospital this summer!

Mary Lou Tate, Controller, Holy Rosary Medical Center



Mary Lou graduated from Gonzaga University with a BS in Biology in May of 1998. She then attended Wayne State University from 1998-1999 where she was studying for her PhD in Cancer Biology Research. Mary Lou then relocated to Boise, ID in May of 1999 and began working for a privately held real estate investment firm. She worked her way up through the company eventually becoming the Portfolio Manager. She then joined Mercy Medical Center in Nampa in July of 2003 as their Financial Analyst. Mary Lou earned her Masters of Science in Accounting from BSU in December 2004. Most recently, Mary Lou was hired in November 2009 by Holy Rosary Medical Center as their Controller. Mary Lou and her husband, Charles, have 4 children, 3 boys and 1 girl, ages 2-15. They live in Nampa, ID. Mary Lou enjoys camping, gardening, scrapbooking, and cross-stitch.

John A. Figgat, Account Executive, Professional Credit Service

Trenton Wells, Meridian, ID



HFMA Idaho Chapter—Educational Events Calendar



May 26-28, Joint Meeting with Washington Chapter

- *Spokane, WA at the Davenport Hotel*
- *Board Meeting—May 26th at 6:00pm at PF Chang's*

July 14-16, Summer Meeting

- *McCall, ID at the Shore Lodge*
- *Board Meeting—July 14th at 6:00pm, location TBD*

October 3-5, Idaho Hospital Association Joint Meeting

- *Sun Valley, ID at the Sun Valley Resort*
- *Board Meeting—October 3rd, time and location TBD*

December 1-3, Winter Meeting

- *Boise, ID at the Grove Hotel*
- *Board Meeting—December 1st, time and location TBD*

TENTATIVE DATE & LOCATION—Spring Meeting, April 13-15, 2011

- *Boise, ID*

Short-lived Financing Options Can Make Capital Projects Feasible in Tough Economy

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It could be said that if the credit markets were not so risk-averse right now, it would be an incredible time to issue debt for expansions, renovations, acquisitions or refinances. Construction costs remain low, and the 10-year treasury rate, an indicator of base interest rates with no risk pricing built in, has been hovering under 4 percent – compared with 6 percent in the late 1990s and 9 percent in the 1980s.

It appears that a “typical borrower” cannot take advantage of these low-cost opportunities to modernize a property, extend service lines or expand a facility because many financing options fell off the table as bond insurers and banks retreated in 2008 and 2009. Credit remains tight, and it seems that only the strongest borrowers can issue debt without enhancement or subsidy at a reasonable cost.

But several credit enhancement and financing options created or modified in the past two years have helped ensure key community resources could continue evolving despite the temporarily tough economy. Some allow borrowers to capitalize on local relationships; others allow them to rely on federal credit enhancement or subsidies in ways that weren't possible before. Some work brilliantly for small projects that perhaps would not see any interest from a larger bank; others are being used for huge new facilities.

And some will expire after 2010, before many realize they exist. By looking both locally and federally for financing, providers may find more options available to them in 2010 than they did in 2008 or will in 2011.

Looking Locally: Federal Home Loan Bank

Borrowers that can issue tax-exempt bonds can supplant larger regional or national banks that aren't lending or providing credit enhancement by combining local bank financing with Federal Home Loan Bank (FHLB) credit support to enhance the debt and reduce the interest rate. This opportunity

already existed for housing borrowers, but Congressional legislation opened it up to non-housing borrowers in June 2008. The non-housing permission expires after Dec. 31, 2010.

There are 12 Federal Home Loan Banks nationwide, each with its own credit rating of AA or AAA. The option provides a local-level financing solution on par with what can be offered by the country's strongest investment-grade rated banks. Because many local banks do not maintain investment-grade ratings, they typically could not provide borrowers letter of credit (LOC) enhancement unless a larger national bank also participated, which can become expensive and dilute the local bank's involvement in the community project.

The FHLB LOC wrap is a viable option for small-to-medium-sized projects, but it will be limited by the local bank's capacity to lend. Some smaller banks cannot take on too much exposure to one particular borrower, making loans of over \$15 million or so more difficult for one bank to handle on its own. In the case of a larger project, however, the borrower has the option to involve multiple local banks, so long as the banks will take a parity security position in the collateral. While some banks may be inhibited by market conditions and are holding back on lending to retain liquidity, many other local community banks still have considerable capacity to lend, and are willing to do so. According to the Federal Home Loan Bank of Pittsburgh, which has been aggregating these transactions, more than 100 non-housing FHLB LOC transactions totaling over \$3 billion have been completed nationwide in the past year.

Looking Locally: Bank-qualified Bonds

When tax-exempt bonds are “bank-qualified,” banks can deduct 80% of their purchase and carrying costs, and can pass along the savings to borrowers by way of a reduced interest rate. This provides local banks the opportunity to get involved in a community project by purchasing the bonds directly, and it entices non-local banks to purchase bonds at lower rates because the purchases reduce the banks' tax burdens.

Short-lived Financing Options Can Make Capital Projects Feasible in Tough Economy (Continued)

Until recently, only \$10 million in bonds could be designated bank-qualified by any single bond issuer (often the local municipality) in one year, limiting project sizes. But in 2009, the American Recovery and Reinvestment Act increased the amount of bank-qualified bonds that can be issued to \$30 million and applied this new limit to the borrower, not the bond issuer. After December, though, this limit reverts to the pre-ARRA limit of \$10 million.

Looking Federally: Build America Bonds

Build America Bonds (BABs) were also created by the American Recovery and Reinvestment Act. Public entities (e.g. municipal hospitals or retirement communities) that issue BABs are subsidized for 35% of their interest cost. This means that a county-owned retirement community that issued BAB debt with a 6.5% coupon would pay an effective rate of 4.2%.

BABs must be issued as taxable notes, and in 2009 and 2010 only public entities can use them, and only for new construction, acquisition or other capital expenditures – not for refinancing or working capital

needs. The subsidy can be applied only to the interest coupon cost, not to any fees that are incorporated into the all-in rate.

BABs are set to expire after Dec. 31. The administration's fiscal 2011 budget proposes opening them to nonprofits in 2011, but reducing the subsidy to 28%. Investors have a strong appetite for this structure, and BABs constitute about 20% of the municipal bonds market. As of Jan. 31, there had been 834 issuances in 47 states for a total of \$70.8 billion, according to U.S. Treasury data collected from Bloomberg.

Conclusion

Affordable financing is available via these temporary options, via governmental financing programs and, to some borrowers, via conventional structures such as bank letters of credit or traditional unenhanced bonds. Those that do not take advantage in 2010, however, could be left in an unfriendly meantime if conventional financing options and the credit markets have not recovered more by the time these temporary options expire. Progress means remaining aware of opportunities, understanding each financing option's

Option	Best For	Special Feature	Evolution & Timing
Build America Bonds	Public (e.g. municipal or county-owned) facilities with projects of all sizes	Reimburses 35% of interest cost, or 45% in special reinvestment zones	Build America Bonds were created by the American Recovery & Reinvestment Act. The ability to issue them expires at the end of 2010 but could be extended
Bank-qualified bonds	Mid-size and smaller non-profit projects	Banks receive reimbursement for interest expense related to these tax-exempt bonds, incentivizing them to offer lower interest rates to borrowers	Prior to 2009, bond issuers (e.g. municipalities) could designate up to \$10 million as bank-qualified bonds. The limit was raised to \$30 million for 2009 and 2010 only, and for this temporary period the limit applies to the borrower, not the issuer
Federal Home Loan Bank credit enhancement	Mid-size and smaller non-profit projects	Hospitals can supplant large banks that aren't providing credit enhancement by relying on local bank credit support backed by the AA- or AAA-strength of the Federal Home Loan Banks	Congress opened up FHLB credit enhancement to non-housing transactions in 2008, but permission for hospitals to use the option expires after 2010

More Hospital to Become Eligible to Refinance Debt Through HUD

impact on both the long- and short-term health of the organization, and being prudent in financing decisions.

*By Ken Gould, Vice President, Lancaster Pollard
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The first public option to refinance hospital debt will be made viable for more hospitals if proposed changes are codified later this spring. The new eligibility standards for HUD mortgage insurance, announced in late January, would enable more hospitals, including those below investment grade, to reduce interest rates, exit troubled banking relationships, extend debt amortizations or otherwise alter existing hospital debt structures.

In the Proposed Rule currently published in the Federal Register, HUD emphasizes that its financing is designed for necessary community hospitals that are strong enough to qualify under its relatively conservative underwriting guidelines, but that do not have access to other funding sources. Comments on HUD's revised threshold requirements are being accepted through March 30, and advocates already are developing responses to further refine the criteria.

The Evolution of Refinancing Through HUD

Mortgage insurance can be used by hospitals of all sizes to finance construction and renovation at some of the lowest rates and best terms available. Prior to July 1, 2009, a hospital could refinance debt using HUD mortgage insurance, known as the FHA/HUD Section 242 program, only if 20% of its transaction was made up of money for new projects. The 20% new money requirement was not viable for most hospitals, as taking on additional leverage or the burden of a project was not tenable.

The new-money requirement was eliminated with the Federal Housing Administration's announcement of the FHA Section 242/223(f) refinancing program last July. But vague and restrictive eligibility requirements thwarted hospitals that sought to use the eagerly-awaited option: The required debt service coverage and operating margin ratios for refinancing, for example, were 1.8x and 0.33, contrasted with 1.25x and 0.0 for new construction. An additional requirement that the hospital either have experienced a 1% interest rate increase or be facing an "imminent" increase in its interest rate left doubt as to whether

fixed-rate debt could be refinanced at all.

Hospital advocates nationwide pushed for revisions to the eligibility. The changes were announced Jan. 29 in a Proposed Rule published in the Federal Register for public comment prior to its codification.

How Has Eligibility Changed?

Changes to the refinancing criteria include:

- The required three-year average Operating Margin ratio has been reduced to 0.0% from 0.33%.
- The required three-year average Debt Service Coverage ratio has been reduced to 1.4x from 1.8x.
- The requirement that a hospital have experienced an interest rate increase of at least 1% or face an "imminent" interest rate hike has been replaced with a more flexible and defined standard. Hospitals must now meet three of the following seven criteria to be eligible to refinance:
 - Refinancing would reduce total operating expenses by at least 0.25%
 - The new interest rate would be at least 0.50% lower than the current rate.
 - The current interest rate has increased at least 1 percentage point since Jan. 1, 2008, or likely will increase that much within one year.
 - Annual total debt service is over 3.4% of total operating revenues.
 - Credit enhancement on current financing has been or will be withdrawn or expired, or the enhancement provider has been or will be downgraded.
 - The current financing has overly restrictive bond covenants.
 - Other circumstances demonstrate that the hospital's financial health depends on refinancing.

The hospital must also demonstrate that it provides an essential service to its community and that there are few affordable refinancing options. HUD is also focusing on market need, although this determination can vary in different scenarios. For example, a state-designated Critical Access Hospital will most assuredly receive more scrutiny than a federally-designated Critical Access Hospital, as will a hospital

More Hospital to Become Eligible to Refinance Debt Through HUD (Continued)

Hospitals that meet the above criteria would do well to include FHA in their refinancing considerations because interest rates are lower via HUD financing than via unrated, unenhanced fixed-rate bonds, and HUD's cash collateral requirements are lower than those of many banks.

The traditional 242 program for new construction continues to be an option for independent hospitals, as well as for hospital systems that seek to isolate the credit risk of a single asset (perhaps a smaller hospital in a multi-hospital system). For public-owned hospitals, the 242 program can be utilized in conjunction with Build America Bonds, resulting in a significantly reduced cost of capital.

HUD estimates that it could complete about 40 hospital refinances in calendar year 2010, assuming processing of 60 days for each application. While this timing estimate appears reasonable given the assumed workload, as of early February no hospital refinance has yet been completed to provide an actual comparison. HUD's timing also assumes an even distribution of applications during a calendar year, an assumption that in future years will likely be reasonable.

With the revisions to its FHA Section 242/223(f) mortgage insurance program, HUD has introduced a viable public sector refinance option where none existed before. While certainly not a panacea, the addition of a non-private-sector refinancing choice provides relief to mid-level community hospitals at a time when they need it, and will continue to be worth including in any comparisons of refinancing options even when the market stabilizes.

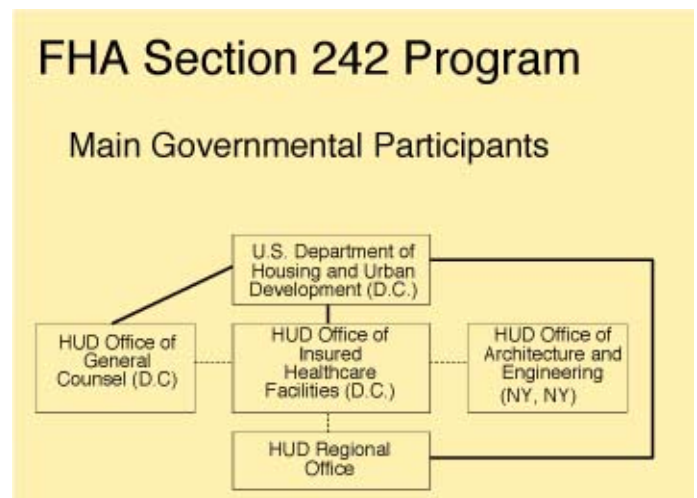
Ken Gould is a vice president with Lancaster Pollard, a leading provider of debt financing and investment advisory services to hospitals nationwide. He can be reached at (614) 224-8800 x119 or kgould@lancasterpollard.com, or visit www.lancasterpollard.com for more information.

<<Sidebar 1: Real-life FHA Refinances>>

A West Virginia hospital has just submitted to refinance its short-term debt structures into a long-term FHA-insured loan under the new eligibility criteria. Debt service is currently high, and the hospital, with \$180 million net patient revenue, is strapped for cash. Refinancing into a 25-year FHA amortization would reduce annual debt service from \$6.5 million to \$2.6 million.

An Illinois hospital, with experience using multiple financing options, is exploring FHA Section 242/223(f) to refinance out of a variable-rate structure enhanced by a letter of credit. The letter of credit fee has increased by 2 percentage points, and it will not be renewed when it expires this year because the provider is no longer interested in smaller hospital credits. Rates on FHA financing, however, are fixed rate, and the mortgage insurance premium will not vary from 0.5%.

In Indiana, a county-run hospital's letter of credit provider was downgraded, and its bonds are now trading at a premium, if at all, causing higher costs even though the hospital's own credit profile was not a factor. The hospital is exploring refinancing with FHA Section 242/223(f).





HFMA Membership

HFMA National's On-line Membership Directory

Have you visited HFMA National's On-line Membership Directory lately? Here's the link: <http://www.hfma.org/login/index.cfm>. When you select "HFMA Directory", not only can you search for members of our chapter, you can also search for all of your HFMA colleagues by name, company, and location - regardless of chapter! Using an on-line directory instead of a printed directory ensures that you always have the most up-to-date contact information.

While accessing HFMA National's On-line Membership Directory, you may view your current contact information and make edits to your profile. You can also view any products you have ordered, events you have registered for, your CPE credits, your Founders points, and more!

It is vital that HFMA has your correct information, so please take a moment to review your record now. By doing so, you will ensure that HFMA continues to provide you with valuable information and insights that further your success.

FY 2011-2012 Idaho HFMA Chapter Leadership Reference Guide

Name	Role(s)	Phone	E-mail
Darci Linstrum	President: Responsible for Chapter operations and communications with members. Leads Board meetings. Represents Idaho Chapter with HFMA National, and at Region 10 Symposium. Coordinates awards and recognition, writes annual report to members. Works with PIPELINE/Website chairs on enhancement initiatives.	509-725-2979 ext 113	linstrd@lhd3.org
Jennie Pipoly	President-Elect: Responsible for quality of programs and that program registrations go out in timely fashion. Works with Member Activities Committee.	(208) 666-2173	jpipoly@kmc.org
Tom Murphy	Secretary: DCMS Contact. Responsible for chapter activity reporting, board and matrix minutes, CPE reporting and all external relations.	(208) 549-4460	tmurphy@weiserhospital.org
Norilina Harvel	Treasurer: Responsible for financial reports, and IRS 990 reporting. Develops the FY09-10 budget. Works with Sponsorship Committees and arranges Chapter financial review.	(208) 265-1101	norilina.harvel@bonnergeneral.org
Kate Homan	Director, Membership Chair Director and coordinator of member functions (membership directory, mailings, meeting registrations & CPE reporting). Social Committee Chair.	(208) 367-4885	kathoma@sarmc.org
Chris Brazil	Director and 1 st past President. Chair of Past President's Council.	(888) 610-5792	cbrazil@outreachservices.com

FY 2011-2012 Idaho HFMA Chapter Leadership Reference Guide

Susan Colburn	Director and 2nd past president. Chair of Nominating Committee.	(208) 799-5200	scolburn@sjrmc.org
Lenne Bonner	Director and Founders and Job Referral Chair	(208) 476-8008	lenne.bonner@smh-cvhc.org
Paul Smart	Director, Joint meeting with WA HFMA Chair; Board Rep for Certification	(208) 852-0137	psmart@fcmc.org
Darci Linstrum	Joint WA/ID meeting Co-chair	509) 725-2979 x113	linstrd@lhd3.org
Carla Terry	Director and Board rep for Sponsorship Committee.	(208) 338-5100 x209	cterry@teamiha.org
Rosa Bowling	Director, Web Master and Newsletter Editor	(509)942-2627	rosa.bowling@kadlecmed.org
Kevin Smith	Director, Idaho Liaison for Region 10 Committee-Education	(208) 344-7150	ksmith@eidebailly.com
Tom Safley	Yeager Award Chair	(208) 799-5303	Tom.Safley@sjrmc.org
Michelle Marcum	Membership Directory Chair	(208) 367-6572	michmarc@sarmc.org

Career Opportunities!



Chief Financial Officer

Avera Sacred Heart Hospital

Cejka Executive Search has been exclusively retained by Avera Sacred Heart Hospital to assist in the recruitment of its Chief Financial Officer. Located high on the bluffs overlooking the Missouri River, Avera Sacred Heart Hospital (ASHH) includes a 140-bed acute care community hospital, six rural health clinics, 187 skilled-nursing beds and management agreements with three rural community hospitals. ASHH is a member of Avera Health, a Catholic health system comprised of five regional health centers throughout the region. www.averasacredheart.com

As an active member of the senior leadership team, the CFO will be a hands-on financial leader as well as a strategic consultant to the president and the Board of Trustees. He/she will be a high energy, professionally seasoned, self-directed finance executive with excellent communication skills. In addition to leading a multidisciplinary team of tenured financial directors to oversee business office, general accounting, HIM, materials management and the Foundation, the organization is seeking candidates who have demonstrated strength in long-and short-term strategic planning. ASHH is a financially successful, stable and exceptionally quality-focused organization.

Successful candidates will have at least ten years of leadership experience in a hospital setting with

knowledge of rural health care finance considered a plus. A master's degree, preferably with a finance focus, is required; CPA is not required but considered a plus.

For more information, please contact:

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2010 – 2011

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