Officer’s Corner

by Vice President Mike Zito,
Managing Director, KPMG LLP

When considering an HFMA membership, we ask ourselves, “What can HFMA do for me?” As addressed in previous articles, advertisements and presentations, it is clear that by becoming an HFMA member we will be provided with:

• Education (and CPE credits) throughout the year on timely and pertinent healthcare topics
  • Opportunities to prepare for and pass healthcare certification exams
  • Access to a wealth of information on national websites and in magazines
  • Opportunities to network with peers on a local and national level

In fact, Maryland and all local HFMA chapters are held accountable on various elements measuring a “successful chapter”, including education hours, membership count, overall membership satisfaction and even the timely reporting of this newsletter. What sometimes gets overlooked and lost in the shuffle is the opportunity HFMA provides its members to give back to their community through charitable efforts.

Michelle Brandt, a Maryland Chapter Board member and Director at MedStar Health’s Managed Care Operations, is the Chairperson of the chapter’s Community Service Committee. A detailed summary of our most recent and subsequent community service events is included on page 12 of this newsletter in the Community Service Corner.

I wanted to take the opportunity to point out some of our chapter’s previous community events as well as summarize what’s in store for the upcoming year.

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Introduction
Since Fall 2010, borrowing costs in the municipal market have been impacted by macro themes, such as the growing optimism of an economic recovery and the Fed’s monetary policy, as well as themes specific to the municipal market, such as the expiration of the Build America Bonds (“BABs”) program, supply/demand factors, and the growing worries related to the credit strength of state and local governments, which has been frequently debated in the media. This article summarizes the current market conditions as well as a brief overview of how healthcare borrowers are responding to the interest rate environment.

Current Fixed Rate Market Environment
For the first 10 months of 2010, the tax-exempt fixed rate market was characterized by record-low absolute interest rates created by positive municipal bond flows and strong institutional investor demand. In September and October, “AA” rated not-for-profit healthcare institutions were able to access the fixed rate market in the high 4.00% range in 30 years, while “A” rated not-for-profit healthcare institutions were in the 5.00% to 5.50% range in 30 years, depending on specific credit quality. However, the interest rate environment changed in November, with yields increasing by more than 100 bps in 30 years. This shift towards higher rates began with the Fed’s announcement that the second round of large-scale asset purchases, called QE2, was going to be concentrated on short to intermediate duration securities rather than long-dated securities, signaling to investors that support to keep long-term yields down was waning. These events, coupled with news pointing to an acceleration in economic growth and potential for rising inflation, put pressure on Treasury yields. The shift to higher rates in the tax-exempt market was influenced not only by these factors but also by specific dynamics unique to the asset class. The American Recovery and Reinvestment Act of 2009 created the BABs program which allowed governmental entities only (option not available to 501(c)(3) organizations) to receive a 35% subsidy on interest payments from the federal government with the issuance of taxable bonds for new money expenditures. The municipal market had been buttressed by the BABs program as it introduced a new buyer base and took almost a third of the long-dated tax-exempt supply out of the market. With the realization that BABs were not going to receive enough political support for renewal at the end of 2010, investors became concerned about increased tax-exempt supply going forward. Additionally, growing worries related to the general credit strength of state and local governments resulted in individuals taking monies out of municipal bond funds. With $3-$4 billion of outflows per week towards the end of 2010 and into January 2011 (depicted in the chart below at left), institutional bond funds were forced to liquidate holdings to fund redemptions, which placed upward pressure on yields. While many of the credit concerns have been focused on general municipal entities, healthcare institutions still have incurred higher interest rates because of the supply/demand imbalance in the market.

As depicted in the chart following, there has been a wide disparity in borrowing costs of institutions with comparable ratings due to multiple factors, including the state (Maryland is a very strong trading state), intra-week volatility, and most importantly, the specific credit profile of the borrower. In this new market environment,
The Patient Protection and Affordable Care Act, and its follow-on legislation, the Healthcare Education and Reconciliation Act of 2010, have been the topics of endless debate. A lot of uncertainty exists around the rules governing implementation of the legislation, funding sources and even the constitutionality of some provisions of the law.

In underwriting the credit of healthcare providers, lenders certainly are attempting to identify and quantify possible risks and/or benefits of the legislation. For hospitals, one anticipated result is that a national trend of declining inpatient utilization could be accelerated by implementation of the law. We believe that the limitations the law places on insurers (prohibition on lifetime dollar limits for essential benefits, inability to charge co-pays/deductibles for medical screenings when writing new policies, prohibition on dropping policyholders who get sick, etc.) will result in insurers incenting policyholders to use lower cost outpatient settings whenever possible. Those restrictions on private insurers may also incent payors to be even more aggressive in negotiating with providers and in denying claims for services. In addition, the law’s many pilots and demonstration projects, including accountable care organizations (ACOs) and medical homes, attempt to realign incentives to care for populations in a more proactive way, which may also serve to reduce acute care volumes.

On the other hand, the estimated 32 million Americans who stand to gain coverage from the ACT, through expanding Medicaid eligibility and income-based subsidies for individuals to purchase private insurance, should result in additional volumes for hospitals and physicians. Assuming the law is implemented as planned, patients who are admitted to an inpatient facility may have a higher likelihood of being insured. The assumed result will be less uncompensated care for hospitals, dramatically reducing DSH payments.

The rate of growth in Medicare reimbursement, however, is projected to slow, particularly as the 2014 date for full implementation of the law approaches. Further, Medicare reimbursement will be tied to quality as measured by performance in predefined areas of care. While all lenders assume their hospital clients will meet the quality benchmarks and achieve the resulting DRG payment increases, there will be offsetting cost incurred for administrative tracking and reporting. Medicare payments are also reduced for “hospital acquired conditions” as another way to incent quality of care; however, the word “condition” is so vaguely defined that hospitals are understandably concerned about this provision. The same holds true for “preventable” readmissions. In aggregate, the quality provisions of the law take money out of provider reimbursement, with reductions in payment tied to hospital acquired infections and preventable readmissions. Value Based Purchasing will be structured as a zero-sum proposition, with “bonuses” being paid to high quality hospitals, as defined, paid for with reductions to the lower quality hospitals.

In addition to monitoring and reporting on quality of care, the law imposes additional administrative burdens on hospitals. Disclosure must be made of financial relationships between a whole host of entities, not-for-profits must perform a community needs assessment every 3 years, and every hospital needs to publish a comprehensive list of charges (including those for DRG’s). Beyond the administrative burden, this last requirement could impact negotiations with health plans or undermine a hospital’s competitive position in a community.

So What Does It All Mean?
The healthcare reform bill can be a mixed bag for providers. Lenders are also struggling to decipher its impacts, particularly since many are still unknown. This uncertainty has been heightened by the recent change in the composition of Congress, as many Republicans are strongly opposed to the bill. Current threats are focused on preventing funding to those agencies which will implement its provisions. Complicating the picture even further are recent court battles challenging the constitutionality of the requirement that consumers purchase insurance, and the need for states to establish insurance exchanges.

The law’s mix of policies which will increase the number of insured Americans, put restrictions on health plan operations, and reduce reimbursement via Medicare, Medicare Advantage, quality provisions and disproportionate share, means that each hospital will have a unique calculus that determines whether they ultimately will benefit or be hurt by the law.

In general, lenders are evaluating hospitals based on 1) operational cash flows—there must be sufficient cushion to withstand the potential impacts of lower revenue, higher physicians salary and benefits and higher administrative costs, 2) a robust cash position—needed for the infrastructure investments in technology, physician base and facilities, and 3) the organization’s prog-
The Financial Accounting Standards Board (FASB) and International Accounting Standards Board (IASB) released an exposure draft titled Leases in August 2010, which contained the boards’ proposal for a new approach to lease accounting. After a significant comment period during which over 800 comment letters were received, the boards reconvened in February 2011 and revised the proposed standard. The final standard on leases is still targeted to be released in June 2011, and it would fundamentally change the way both lessees and lessors account for leases.

Under the proposed model, a lessee’s rights and obligations under all leases—existing and new—would be recognized on its balance sheet. The proposed standard would require lessees to record an asset representing the right-to-use a leased asset over a specific term. Further, lessees would be required to record a liability based on requirements to make future payments.

Under the proposed standard, lessors would recognize an asset for the right to receive payments. Depending on whether they retain exposure to significant risks, the lessor would apply either a performance-obligation approach or a derecognition approach to the leased asset. Under the performance obligation approach (where the lessor retains exposure to significant risks or benefits associated with the leased asset), the lessor would record a liability representing deferred revenue, and this liability would be released as the right of use to the asset is provided to the lessee. Under the derecognition approach, the lessor recognizes revenue for the sale of the right to use the asset and removes from the value of the underlying asset a portion corresponding to the lessee’s right to use the asset (i.e. treats the lease as a part-sale of the asset).

The lease term to consider in applying the accounting treatment under the proposed standard includes the contractual minimum period, plus any optional renewal periods for which exercising the renewal option is considered ‘reasonably certain.’ It should be noted that this is a change from the initial exposure draft which originally proposed a threshold of ‘more-likely-than-not’ regarding lease renewals – comment letters expressed concern that the ‘more-likely-than-not’ threshold would be too low and create complexity and implementation difficulties.

Another change from the original exposure draft was to include a lease classification test to determine the pattern of profit and loss for recognition in the income statement. All leases would need to be classified as either a finance lease or an other-than-finance lease. Finance leases would include a financing element (lessor providing financing to the lessee) and interest would be computed using the effective interest method. Other-than-financing leases would be akin to a rental transaction and financing would not be considered a significant component of the lease. Under other-than-financing profit and loss would be recognized on a straight line basis.

Almost all companies would be affected should the proposed standard be adopted. However, companies who typically utilize operating leases under current GAAP would be most affected as all leases would now come onto the balance sheet. Changes to companies’ balance sheets would include reporting assets at an amortized cost value of the right of use assets, and reporting liabilities at the amortized cost value of the leased liabilities. Amounts reported as operating rent expense would be replaced by amortization of the right of use asset as well as interest expense on the lease liability. Interest expense would most likely be higher in earlier periods under the effective interest method. On the statement of cash flows, lease payments would be shown as a component of financing activities, potentially increasing cash flows from operating activities.

Even as reported leased assets and liabilities would likely increase, companies’ should not expect their ratings to change as the rating agencies are sensitive to the differences in accounting approach and treatment. However, companies should also consider any implications that the proposed standard will have on debt covenant compliance and or borrowing capacity. Some companies might try to renegotiate how financial ratios specified in covenants are calculated and or consider obtaining waivers. Over the long term, companies might change their lease-versus-buy strategies or negotiate different lease terms.

The FASB and IASB have prioritized the concerns...
It is widely known that there is diversity in practice regarding how health care entities recognize revenue. The general industry practice is to recognize revenue (excluding charity care) when services are provided and to adjust for contractual allowances based on third party-payor or other arrangements. The patient’s “ability to pay” is usually not taken into consideration by health care organizations when initially recognizing revenue but instead bad debt expense is recorded based on collection history.

The Emerging Issues Task Force (EITF) proposed EITF 09-H to address concerns around revenue recognition practices—primarily whether a health care organization should consider collectability in determining the timing and amount of revenue recognition. The EITF deliberated this issue at their September 2010 meeting and the options considered included a) collectability should be reasonably assured at patient...
Maryland Medicare Advantage Enrollment Bucks the National Trend

By: Michael L. Wertz, Director Managed Care, University of Maryland Medical Center

Each year during the month of December, Medicare conducts its open enrollment period allowing Medicare eligible beneficiaries to choose between traditional Medicare or a Medicare Advantage (MA) program through a private health plan. Members already enrolled in a MA plan have from January through mid-February to switch back to traditional Medicare if they so choose. The 2011 open enrollment results are in!

Although MA enrollment continues to grow, the Maryland market penetration (7.8%) remains below the high of 9.4%, set in 2000, and the national average of 24%. As of February 2011, CMS reports there are 61,806 MA enrollees in Maryland belonging to fourteen different payor organizations.

Beginning in 2011, CMS required private-fee-for-service (PFFS) plans to develop contracted networks or discontinue offering their products. The PFFS market saw a marked decrease in enrollment in Maryland as many payors stopped offering the program, with some dropping out of the MA market altogether. The drop in PFFS enrollment was offset by membership growth in the HMO and PPO programs. Aetna (10,891), Bravo Health (17,818) and Kaiser (23,813) lead the market in Maryland MA membership. The following table provides plan specific details.

References
1 Henry J. Kaiser Family Foundation, Medicare Advantage Fact Sheet, September 2010

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Grand Total Medicare Advantage Membership: 56,241 61,806
Total Medicare Eligibles: 771,572 792,626
Market Penetration: 7.3% 7.8%

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% Total

HMO 40.6% 41.7%
PPO 9.6% 15.9%
PFFS 11.5% 3.6%
COST 38.1% 38.6%
PACE 0.2%
ICD-10 Transition Basics

By Traci La Valle
Vice President, Financial Policy
Maryland Hospital Association

WHAT: On January 16, 2009, the U.S. Department of Health & Human Services (HHS) released the final rule mandating use of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for diagnosis coding; and the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) for inpatient hospital procedure coding on October 1, 2013. The standards for use in reporting diagnoses and inpatient hospital procedures in health care transactions adopted under this rule will replace the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Volumes 1 and 2, and the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Volume 3 for diagnosis and procedure codes, respectively, developed nearly 30 years ago. The ICD-10-CM code set is maintained by the National Center for Health Statistics (NCHS) of the Centers for Disease Control and Prevention (CDC) for use in the United States. It is based on ICD-10, which was developed by the World Health Organization (WHO) and is used internationally. The ICD-10-PCS code set is maintained by the Centers for Medicare & Medicaid Services (CMS). The final rule does not change the standard for outpatient procedure coding--Current Procedural Terminology (CPT) codes, maintained by the American Medical Association.

WHEN: ICD-10 codes must be used on all Health Insurance Portability and Accountability Act (HIPAA) transactions, including outpatient claims with dates of service, and inpatient claims with dates of discharge on and after October 1, 2013.

WHO: All entities covered by HIPAA--not just providers who bill Medicare and Medicaid--must begin using the ICD-10 codes.

WHY: The transition to ICD-10 is occurring because ICD-9 is able to produce only limited data about patients’ medical conditions and hospital inpatient procedures. The structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full. ICD-9 is 30 years old, uses outdated terminology, and is inconsistent with current medical practice. Transitioning to ICD-10 will provide more specific coding and more clinical information, which will result in improved ability to measure health care services; increased sensitivity when refining grouping and reimbursement methodologies; more meaningful comparison of morbidity, mortality, and other outcomes data; enhanced ability to conduct public health surveillance; and less need to include supporting documentation with claims.

Comparison of ICD-9 to ICD-10

Coding under ICD-10 is more specific and substantially different from ICD-9 coding. There is a seven-fold increase in the number of ICD-10 diagnoses and procedure codes compared to ICD-9. In the 2009 versions, the number of available codes is as follows:

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<td>ICD-9</td>
<td>14,025</td>
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A simple crosswalk between ICD-9 and ICD-10 is not sufficient to translate the one-to-many relationships between ICD-9 and ICD-10. In some cases, a single ICD-9 code could be represented by multiple ICD-10 codes and for other conditions, a single ICD-10 code may require multiple ICD-9 codes. In addition, some ICD-10 codes have no predecessor ICD-9 codes.

Tools to Assist the Transition

General Equivalence Mappings (GEMs)

CMS and the CDC created the GEMs to convert data coded using ICD-9 to ICD-10 and vice versa. The GEMs have been used to:

- Translate ICD-9 codes in the official coding guidelines in preparation for production of the official ICD-10 coding guidelines.
- Convert version 26.0 of Medicare Severity Diagnosis-Related Groups from an ICD-9-CM-based application to an ICD-10-CM/PCS-based application;
- Convert the Medicare Code Editor to a native ICD-10-CM/PCS-based application;
- Produce an ICD-10-CM/PCS to ICD-9-CM crosswalk for reimbursement called the ICD-10 Reimbursement Mappings.

Reimbursement Mappings

The ICD-10 reimbursement mappings were developed by CMS in response to non-Medicare payor requests for a standard one-to-

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Capturing Payment from the Under-Banked

by Gus Bessalel

Abstract: Adding a channel to accept cash payments can enable medical providers to serve the 25% of U.S. households who cannot use credit or debit cards to pay.

A whopping 60 million adults in the U.S. operate outside of the financial mainstream. These households operate on a daily basis without using credit or debit cards and often do not even have checking accounts. Structural limitations or distrust towards financial institutions drive them to alternative financial products to execute transactions. Often, they simply operate in a cash economy, even when other payment options are available to them.

While there is a substantial movement by healthcare providers to capture patient balances at the point of service, the reality is that the vast majority of patient balances are still billed after service has been provided. For health-care providers who bill patients after providing treatment, the challenges of collecting from patients who use traditional financial instruments such as payment cards is already hard enough. But collecting payment from patients who have no checking accounts or payment card options generally proves to be impossible, with collection rates often falling well below 10 percent.

According to a 2009 FDIC study, 23 percent of those who earn less than $50,000 per year do not use a regular checking or credit product. Not surprisingly, these low income households are also 40 percent less likely to carry health insurance, creating a double whammy for health-care providers. Not only can’t providers get paid by insurers, but the patients who fall into this category do not have access to the traditional means of satisfying their bills—paying by credit card or by check. If these patients want to pay in cash, often the only choice most have today is to actually visit the provider in person to conduct the transaction.

Over the past 10 years, as an extension of the debit card industry, there has been an explosion in the proliferation of pre-paid payment cards. Starting with the gift card industry, MasterCard and Visa among others, have led the way in issuing tens of millions of special purpose payment cards. Many employers have begun to use these stored value cards to turn paychecks into card balances that serve as a virtual bank account for the cardholder. The accounts have the benefit of eliminating the need for expensive check cashing services and also provide a greater measure of security as these employees do not need to carry and store their pay in cash.

But despite the availability and growth of these new pre-paid card options, for many under-banked individuals, cash remains the financial instrument of choice. As healthcare providers consider how to tackle the ever-increasing challenge of dealing with self-pay balances, broadening the options for patients to pay their bills is key. Many hospitals have adopted innovative programs to help patients finance their medical debt, to pay in installments, to receive pre-paid discounts, and to pay online. A few hospitals have partnered with money transfer services like Western Union to create a more convenient option for patients to pay in cash, but the fees associated with such transaction fees can often be onerous on the patient. In most cases, if a patient wants to pay in cash, the typical facility has no easy option.

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By Michael Brozic, Audit Senior Manager, KPMG

Where do you work?
At KatzAbosch, a leading regional accounting & consulting firm based in Timonium, MD. I am a Shareholder and Chair the Medical Practices Services Group at the firm.

Why did you join the HFMA?
To learn more about healthcare financial management in an effort to build on my expertise in the medical practice industry. In the current environment, where many hospitals are joint venturing with medical practices, it’s even more important for me to gain a better understanding of the hospital side to help bridge the gap between physicians and hospitals. I also appreciate the networking opportunities and opportunity to build new relationships.

Have you joined a committee?
Yes, the newsletter committee.

Are you going to work towards certification?
As a new member, I am looking forward to learning more about the process and benefits of certification.

What do you want to get out of your HFMA experience?
I would like to learn more about healthcare financial management, continue to build my network and to be better equipped to provide timely, meaningful advice to my clients.

Who was the first member you met?
About 2 years ago, I met with George Bayless and Eric Melchior on other business matters. We discussed the HFMA at that meeting and they encouraged me to join.

Tell us about you...
I am originally from Easton, Maryland and graduated from Salisbury University. I obtained my CPA license in 2001 and joined KatzAbosch in September of 2002, where I promoted to partner within 6 years of joining the firm. I am a busy, working mother of twin daughters that are 6 and another daughter who’s 9. I am blessed with a wonderful family and a successful, fulfilling career at KatzAbosch!
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Interview with Laurie Beyer, CFO

1. What is the biggest challenge you face as CFO? A: Being able to manage the utilization of services while managing expenses. We are challenged by seasoned physicians who are not aligned with the hospital properly and are resistant to change the way they practice. Ed Henry, Director of Revenue Cycle added that probably one of the biggest challenges the hospital faces is being nimble enough to change, as a provider, in response to the regulatory environment.

2. What activities/committees have you or your team participated in as part of HFMA? A: Over the years, I have served in a number of roles with the Maryland Chapter. I was on the Social Committee, the Newsletter Committee as well as the Strategic Planning Committee. I also had the opportunity to serve on the Program Committee which was truly beneficial as we worked to make sure that our educational programs were current and addressing the issues that the membership was truly interested in. I was also a part of the Committee that worked on the Annual National Institute when it came to Baltimore. That was a great experience as we demonstrated pride in our City and our Chapter. I was also a member of the Chapter Board of Directors for a three-year term.

3. How has being a part of HFMA helped you and your staff? A: The networking aspects of...
The Maryland Chapter of HFMA has been fortunate to have the continued support of M&T Bank, both as an Annual Platinum Sponsor, but also their participation on many committees and assistance with educational sessions and events. The Chapter wishes to thank M&T for their support. Below is a brief description of M&T’s Healthcare Banking Practice and Team.

Healthcare institutions benefit from the support of a strategic partner who thoroughly understands their business. M&T Bank’s Healthcare Banking team brings clients more than 30 years of healthcare industry experience.

Established more than 20 years ago, M&T’s Healthcare Banking Group was built on a strong working knowledge of the healthcare industry. Dedicated relationship managers work with clients to fully understand the demands and needs of their business and offer customized solutions. M&T’s full product line includes deposit and treasury management services, financing and leasing options, investment banking and trust and custody.

M&T Bank’s Mid-Atlantic headquarters is in Baltimore. M&T Bank Corporation was founded in 1856 and is one of the 20 largest US headquartered commercial bank holding companies with more than $68 billion in assets. M&T operates more than 725 branches throughout New York, Maryland, Pennsylvania, Virginia, West Virginia, Delaware, Washington, DC and Ontario, Canada. M&T Bank is one of the best performing regional banks in the nation today. With a longstanding tradition of careful, conservative and consistent management, the bank has generated positive earnings and positive capital—despite the ongoing turbulence in the economy.

While M&T’s healthcare banking efforts are managed in Baltimore, the group works with clients located throughout the Mid-Atlantic region. Relationship managers work with clients in acute care, home healthcare, long term care and senior housing, physician practice and managed care segments. These relationship managers take time to fully understand clients’ business objectives in order to recommend the right product solutions to help meet their goals.

M&T Bank has supported and been actively involved in HFMA for more than 20 years. A current platinum sponsor, M&T has encouraged employee leadership involvement in HFMA. HFMA Director, Hannah Lowe, a healthcare specialist with the M&T Investment Banking Group, currently serves as webinar chairperson. Annual Institute committee member Lara Chamberlain, a healthcare relationship manager, organized the Wednesday Night Reception river-boat cruise for the 2010 Annual Institute, an event M&T Bank sponsored.

During a recent HMFA education session, Jim Hannan, senior fixed income portfolio manager for MTB Investment Advisors, provided information on investment products and market intelligence.

Through the years, M&T employees have benefited from the partnership with HFMA as it is an invaluable resource and network for anyone in the healthcare industry. To learn more about M&T’s Healthcare Banking Group, visit www.mtb.com/commercial/healthcare.
HFMA members gathered at Dave and Buster’s in Arundel Mills on February 17th to mingle and network. While some sat and chatted over drinks and appetizers, others played competitive games of pool. There were a fair number of new members in attendance: we even had a few new folks make the trek up from DC! It was a relaxing evening getting to know new friends and reconnecting with familiar faces.

Then, on April 7th, we had a bowling showdown at Mustang Alley’s in Fells Point, organized by committee member, Ben Shifflet. The Maryland HFMA Board fielded a ten-pin team, with current President, Eric Melchior, leading the motivation squad and past President, George Bayless, leading in points scored. Members, non-members and new members mixed on the other lanes creating an atmosphere of competition and energy.

Please be sure to join us at our next event: PICNIC AND FAMILY FUN DAY at Oregon Ridge Park Saturday, June 18, 2011 Cost: FREE! Time: TBD

On February 4, 2011 the Maryland Chapter of HFMA collected many useful items for the House of Ruth residents. The House of Ruth provides shelter to women and children who are victims of violence. The House of Ruth leads the fight to end violence against women and their children by confronting the attitudes, behaviors and systems that perpetuate it, and by providing victims with the services necessary to rebuild their lives safely and free of fear. We’re pleased that our organization’s collection was a success and that we could give so many items to the House of Ruth to support the women and children who are hopefully starting a new (safe!) chapter in their lives. Items donated consisted of the following:

- Gift cards: Visa, Safeway, Target and Walmart
- Multiple sets of sheets, pillowcases, pillows
- Multiple sets of towels and wash cloths
- Large winter blankets
- Laundry baskets
- Shampoo bottles
- Ladies’ Deodorants
- Hairbrushes
- Undergarments and shirts for adult women
- Baby outfits
- Diapers and baby wipes
- Dirt devil vacuum

Thank you HFMA members for your generous support!

Looking ahead
The Community Service Committee will be collecting used professional and business casual clothing at the HFMA June 18th Family Picnic. Your donations of men’s clothing (including suits, ties, shirts, shoes, belts, etc.) will be given to “Million Dollar Man,” and donations of women’s clothing (including suits, jackets, skirts, dress pants, blouses, jewelry, shoes, purses, and accessories) will be given to “Suited to Succeed.” Both organizations provide professional attire at no cost to individuals working to enter or re-enter the workforce.

Please take this opportunity to clean out your closets, and provide someone else with an opportunity for career success! If you do not have clothing to donate, we will also accept postage stamps, or gift certificates for dry-cleaning, printing, or salon services. More information can be found at www.milliondollar-man.org and www.suitedtosucceed.org.

In addition, at the Family Picnic we will give the kid attendees an opportunity to write a thank you letter, card and/or draw a picture to our troops and wounded warriors through Operation Gratitude.

So come and let’s all have some fun at the HFMA June 18, 2011 Family Picnic!
HFMA is pleased to announce that the Association's Board of Directors has nominated Ralph E. Lawson, FHFMA, CPA, and Steven P. Rose, FH-FMA, CPA, to stand for election to the Board for the positions of Chair-Elect and Secretary/Treasurer for 2011-2012.

Lawson is executive vice president and CFO, Baptist Health South Florida, Coral Gables, Fla., and a member of HFMA's Florida Chapter. He joined HFMA in 1980 and has served the Association nationally on HFMA's Board of Directors and as a member of the Executive Committee, the Audit & Finance Committee, the National Advisory Councils, and the National Matrix. He is actively involved with the Florida Chapter. Lawson also is a past-president of the Colorado Chapter.

Rose is CFO at Conway Regional Health System, Conway, Ark., and a member of HFMA's Arkansas Chapter. Since joining HFMA in 1985, he has served the Association nationally on HFMA's Board of Directors and as a member of the Executive Committee, the Audit & Finance Committee, the Strategic Planning Committee, and the Revenue Cycle KPI Task Force. Rose has also served as president, secretary, and treasurer for the Arkansas Chapter, among other leadership roles for the chapter, and has served as a regional executive.

Three HFMA members have also been chosen to stand for election as 2011-14 Directors:
- Reginald J. Albert, FHFMA, MBA, is vice president, physician practices, PenBay Healthcare, Rockport, Maine.
- Kim Griffin-Hunter, CPA, MBA, is the national leader of the AERS Life Sciences & Healthcare practice and a partner in the South Florida practice of Deloitte & Touche.
- Rebecca L. Speight, FHFMA, CPA, is CFO, Bailey Medical Center, Owasso, Oklahoma.

Board elections will take place in May 2011.

Welcome Maryland HFMA New Members

Andrew Clark
Anne Arundel Medical Center

Michelle Coleman
Doctors Community Hospital

Yoland Ezell
American Express

Michele Lagana
Baltimore Medical System, Inc.

Robert McMillan
Blue Cross Blue Shield Association

Jeffrey Trimmer
St. Joseph Physician Enterprise

Deandra Walker
Shore Health System, Inc.

Beth Wieczorek
MedSpeed

Darleen Won
LifeBridge Health

Ernest Wyatt
PricewaterhouseCoopers LLP

Register Now for HFMA’s 2011 ANI: 
The Healthcare Finance Conference

Join us in Orlando, Florida June 26-29, 2011 for a powerful line-up of best-practice sessions led by industry leaders and covering important topics such as Reform, Value, Clinical Transformation, Accountable Care, and Revenue Cycle. In addition, multiple networking opportunities and 27.5 CPEs ensure a valuable experience. Learn more and register – early-bird pricing now available (http://www.hfma.org/ai).
The Maryland Chapter held its annual election of Officers and Directors this past March. This year was our second year using an automated online process giving all eligible Chapter members greater access to the voting process. The results are in... please join The Chesapeake Bayline in congratulating our new incoming leaders.

Their terms begin on June 1, 2011.
Officers-
Jennifer M. Maher, President
Michael A. Zito, Jr, President-Elect
Charles A. Zorn, Vice-President
Scott Furniss, Secretary
Kelly Henneman, Treasurer

Directors-
Traci LaValle, MHA Liaison
Hannah Lowe (Term expires 2012)
Craig Masters (Term expires 2012)
Joshua A. Campbell (Term expires 2013)
Michael D. Myers (Term expires 2013)

**October 5th-7th, 2011**

MD HFMA Annual Institute

We have a variety of topics and guest speakers you will not want to miss! We are also offering special rates if you are not able to participate in the entire event.

Book your room today! Mention MD HFMA for discounted rates.
Reservations: 301-965-4000
Deluxe room rate $199/Atrium room rate $239
201 Waterfront Street
National Harbor, MD 20745
Upcoming Maryland HFMA Educational Programs

May 20, 2011
Legislative Update
Maryland Hospital Association
Hanover, MD

August 19, 2011
Healthcare & Regulatory Update
Sheppard Pratt Conference Center
Towson, MD

September 16, 2011
A Look at America’s Looming Doctor Shortage
(Breakfast Meeting)
Sheraton BWI Hotel
Linthicum Heights, MD

October 5-7, 2011
41st Annual Maryland Chapter Annual Institute
Gaylord National Hotel & Conference Center
National Harbor, MD

Maryland Chapter Officers & Directors
2010 - 2011

Eric Melchior, President
emelchior@gbmc.org, 443-849-2511

Jennifer Maher, President-Elect
jennifer.m.maher@medstar.net, 410-772-6512

Mike Zito, Vice President
mazito@kpmg.com, 410-949-8444

Chuck Zorn, Secretary
czorn@mcbllc.com, 410-828-0534

Scott Furniss, Treasurer
sfurniss@stagnes.org, 410-368-3130

Tom Trzcinski, Director (2009-2011)
ttrzcinski@jhmi.edu, 410-550-9645

Kelly Henneman, Director (2009-2011)
khenneman@umm.edu, 410-328-1386

Hannah Lowe, Director (2010-2012)
hlowe@mtb.com, 410-244-4836

Craig Masters, Director (2010-2012)
craig_masters@bshi.org, 410-528-4829

Michelle Brandt, Director (2010-2012)
michelle.brandt@medstar.net, 410-933-3015

Traci LaValle, MHA Liaison
tla_valle@mhaonline.org, 410-379-6200

George Bayless, Past President
gbayless@gbmc.org, 443-849-4311
where fewer transactions are insured, institutional investors are scrutinizing financial performance and making purchasing decisions based on their views on how the individual credit will respond to changes in healthcare going forward. Thus, healthcare institutions with strong fundamentals and positive credit trajectories have outperformed, in terms of yield, those with weaker financial performances.

During February and March, the tax-exempt fixed rate market stabilized as bond outflows have decelerated (although still negative each week), crossover buyers, such as hedge funds, have entered the arena, retail buyers have increased their purchases, and tax-exempt supply has significantly diminished.

As depicted in the charts on the following page, the lack of tax-exempt supply has been the primary driver of slightly lower interest rates in February and March. Going forward, long-term tax-exempt yields likely will be influenced by macro themes, such as the impact of the tsunami in Japan, the unrest in Libya and other Middle East events.

### Select Recent Fixed Rate Healthcare Transactions

<table>
<thead>
<tr>
<th>Obligor</th>
<th>Rating</th>
<th>Par ($MM)</th>
<th>Sale Date</th>
<th>MMD at Final Maturity (%)</th>
<th>Spread to MMD (bps)</th>
<th>Yield to Call (%)/Final Maturity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cottage Health System (CA)</td>
<td>NR/A+/AA</td>
<td>292.600</td>
<td>10/5/2010</td>
<td>3.74</td>
<td>+126</td>
<td>5.00 (2040)</td>
</tr>
<tr>
<td>Trinity Health (Multi)</td>
<td>Aa2/AA/AA</td>
<td>252.460</td>
<td>10/12/2010</td>
<td>3.68</td>
<td>+96</td>
<td>4.64 (2037)</td>
</tr>
<tr>
<td>Allegiance Health (MI)</td>
<td>NR/A-/NR</td>
<td>99.055</td>
<td>10/13/2010</td>
<td>3.70</td>
<td>+160</td>
<td>5.30 (2037)</td>
</tr>
<tr>
<td>Christiana Health (DE)</td>
<td>Aa3/AA-/NR</td>
<td>73.000</td>
<td>10/18/2010</td>
<td>3.77</td>
<td>+83</td>
<td>4.60 (2040)</td>
</tr>
<tr>
<td>Kings Daughters Health (IN)</td>
<td>Baa2/NR/BBB+</td>
<td>100.035</td>
<td>10/19/2010</td>
<td>3.77</td>
<td>+198</td>
<td>5.75 (2045)</td>
</tr>
<tr>
<td>Novant Health (NC)</td>
<td>A1/A+/AA-</td>
<td>264.165</td>
<td>10/21/2010</td>
<td>3.77</td>
<td>+123</td>
<td>5.00 (2043)</td>
</tr>
<tr>
<td>Piedmont Health (GA)</td>
<td>Aa3/AA-/NR</td>
<td>100.000</td>
<td>10/21/2010</td>
<td>3.77</td>
<td>+105</td>
<td>4.82 (2045)</td>
</tr>
<tr>
<td>Yale-New Haven Hospital (CT)</td>
<td>Aa3/A+/NR</td>
<td>104.390</td>
<td>12/15/2010</td>
<td>4.85</td>
<td>+76</td>
<td>5.61 (2040)</td>
</tr>
<tr>
<td>NYU Hospitals Center (NY)</td>
<td>Baa1/BBB+/BBB+</td>
<td>130.930</td>
<td>1/6/2011</td>
<td>4.74</td>
<td>+141</td>
<td>6.15 (2040)</td>
</tr>
<tr>
<td>Partners Healthcare (MA)</td>
<td>Aa2/AA/AA</td>
<td>130.085</td>
<td>1/6/2011</td>
<td>4.74</td>
<td>+71</td>
<td>5.45 (2041)</td>
</tr>
<tr>
<td>San Antonio Community Hospital (CA)</td>
<td>A3/A/AA</td>
<td>124.605</td>
<td>1/12/2011</td>
<td>4.92</td>
<td>+183</td>
<td>6.75 (2041)</td>
</tr>
<tr>
<td>Sutter Health (CA)</td>
<td>Aa3/AA-/AA-</td>
<td>750.000</td>
<td>1/25/2011</td>
<td>4.83</td>
<td>+137</td>
<td>6.20 (2042)</td>
</tr>
<tr>
<td>Hoag Memorial Hospital (CA)</td>
<td>Aa3/AA/AA</td>
<td>105.390</td>
<td>1/26/2011</td>
<td>4.81</td>
<td>+126</td>
<td>6.07 (2040)</td>
</tr>
<tr>
<td>Union Hospital (IN)</td>
<td>NR/NR/NR</td>
<td>55.040</td>
<td>2/11/2011</td>
<td>4.90</td>
<td>+330</td>
<td>8.20 (2041)</td>
</tr>
<tr>
<td>UPENN Health System (PA)</td>
<td>Aa3/AA-/NR</td>
<td>150.000</td>
<td>2/16/2011</td>
<td>4.82</td>
<td>+106</td>
<td>5.88 (2041)</td>
</tr>
<tr>
<td>Swedish Health (WA)</td>
<td>A2/NR/A+</td>
<td>175.000</td>
<td>2/16/2011</td>
<td>4.82</td>
<td>+164</td>
<td>6.46 (2041)</td>
</tr>
<tr>
<td>Lifebridge Health (MD)</td>
<td>A2/A/NR</td>
<td>50.695</td>
<td>3/17/2011</td>
<td>4.68</td>
<td>+142</td>
<td>6.10 (2040)</td>
</tr>
<tr>
<td>Tufts Medical Center (MA)</td>
<td>NR/BBB/BBB</td>
<td>210.000</td>
<td>3/24/2011</td>
<td>4.73</td>
<td>+220</td>
<td>6.93 (2041)</td>
</tr>
<tr>
<td>Wentworth Douglas Hospital (NH)</td>
<td>NR/A/A</td>
<td>87.920</td>
<td>3/30/2011</td>
<td>4.76</td>
<td>+192</td>
<td>6.68 (2038)</td>
</tr>
</tbody>
</table>

Source: Morgan Stanley
Eastern nations, the European debt crises, overall economic growth and the interest rate environment in the U.S., as well as specific factors unique to the municipal sector, such as credit and new issue tax-exempt supply. There is concern among market participants that an increase in supply will put pressure on the market, resulting in higher tax-exempt yields.

Response of Healthcare Borrowers and Short-Term Market Environment

Through March 2011, the lighter supply in the not-for-profit healthcare market has been a function of a few factors. Firstly, higher interest rates have negatively impacted refunding savings. With most of the variable rate restructurings accomplished in 2009 and 2010 and very few current refundings executed this year because of higher rates, refunding supply has diminished. Secondly, many healthcare institutions accelerated their new money borrowings over the last few years because of historically low fixed rates. Thirdly, healthcare organizations have been focused on strategy discussions more than capital market activities given the fundamental changes which are occurring in the healthcare industry. Finally, healthcare institutions are taking this opportunity to reevaluate their capital structure and to undertake asset-liabilities studies and enterprise risk management analyses. With higher long-term rates, more institutions are considering utilizing variable rate debt for a portion of, or all of, their upcoming borrowings. This is a dramatic shift compared to the last three years when most of the issuance was in the form of traditional fixed rate debt.

Borrowers are contemplating variable rate debt because short-term tax-exempt interest rates remain extremely low. Although money market funds continue to lose monies, the lack of new VRDB issuance, the elimination of VRDB programs from the market, and general low short-term interest rates have kept SIFMA, the tax-exempt short-term weekly index, under 0.35% each week since January 2010. VRDBs continue to trade at a spread to SIFMA, depending on the creditworthiness and ratings of the bank support utilized. In terms of the bank LOC market, while a significant amount of renewals are projected to occur in 2011 and 2012, there are a number of new entrants to the market, allowing bank providers to be aggressive in providing capacity at reasonable fees and terms to healthcare borrowers. This is a shift compared to 2008.
and 2009, when LOC fees were significantly higher and commercial banks were reducing their bank support.

Given the higher long-term interest rate environment and the overweighting of fixed rate loans in the capital structure, some health care institutions are considering variable rate options which do not require bank LOC or liquidity support and provide access to the short and intermediate portions of the yield curve, where rates remain low. These alternatives include new products, such as SIFMA Index Bonds and Windows (product mainly for “AA” borrowers, as well as other variable rate alternatives, such as Multi-Anual Put Bonds, Serial Mode Bonds, directly purchased variable rate notes, and Synthetic Variable Rate Debt.

If you have any questions on the information provided in this update, please feel free to contact david.gallin@morganstanley.com.

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Officer’s Corner
Continued from Page 1

In the past, the Maryland Chapter has participated in: serving meals at soup kitchens; clothing drives for the homeless and less fortunate; painting a mural for the Healthcare for the Homeless site; organizing a group to participate in the “Race for the Cure”. Many of our members have participated in these events which are a great way to support the community.

Events for the upcoming year include but are not limited to the following:

• Clothing drive at the June 18th Family Picnic (see Community Service Corner for details)
• Filling of shoe boxes with Holiday items for needy children (to be held at this year’s Annual Institute)
• Collection of hats, gloves and warm socks for shelters in December 2011
• Bringing meals and serving at a soup kitchen in January 2012
• Participating in a Charity Walk/Run in the Spring of 2012

The Maryland Chapter has been committed to providing quality educational programs and meeting our national “Scorecard Targets”. We are also committed to providing you the opportunity to give back to your community through our many charitable initiatives.

Thanks to all of you who have participated in these worthy causes in the past. We hope many of you will get involved with our Community Service Initiatives in the upcoming year!

Healthcare Reform & Lending - What’s Changed for Underwriting
Continued from Page 3

New Approach to Lease Accounting
Continued from Page 4

The FASB and IASB have prioritized the concerns raised through the comment letter period, and prior to finalizing the standard will focus on the following: clarifying the definition of a lease, the lease term, impacts of variable lease payments, measurement (including discount rate considerations), accounting for lease incentives and modifications, transition considerations, disclosure requirements, and private company considerations. In addition, other comment letters expressed concern that lessor accounting was substantially less developed than lessee accounting. The boards will consider all of these priorities, and will publish additional information over the coming months. The targeted release date for the final standard is June 2011, and as such, no effective date has been determined. For now, stay tuned!

Provider Profile - Union Hospital of Cecil County
Continued from Page 10

membership are extremely beneficial. I recall having a complex issue which required the hospital’s strategic attention (evaluating observation stays vs. inpatient admission) and I was able to reach out to another colleague who I had met through HFMA and discuss the issue one of one with him. That probably wouldn’t have been possible if it hadn’t been for HFMA.

4. What one thing does our Chapter do that helps the most? A: I think the chapter does a good job of disseminating information to keep the membership abreast of the important issues facing the industry and finance personnel in particular. Ed Henry credited the Chapter with providing helpful information on best practices. James Raab, an HFMA member for approximately 30 years, suggested that it would be helpful if there were even greater collaboration with AHAM. Carla Moore, Director of Finance added that the conferences are truly helpful (FASB updates, ICD10) and would welcome the opportunity to participate via teleconferencing as the travel distance can be a challenge.
Revenue Recognition

Continued from Page 5

level prior to any recognition of revenue, b) collectability should be reasonably assured at portfolio level prior to recognition of any revenue, c) net bad debt expense against patient revenue, and or d) increase and update related disclosures.

The EITF determined that rather than changing the entire revenue recognition model, revenue recognition for health care organizations could be sufficiently addressed by changing where bad debt expense is recorded in the income statement and increasing related disclosures.

Bad debt expense will be separately presented as a component of and reduction to gross revenue. Further, companies will be required to expand disclosures to include their policy for considering collectability in the timing and amount of revenue and bad debt recognized, net patient revenues for the period by category of payor – such as third-party payors and self-pay patients, and reconciliation of the material activity in the allowance for doubtful accounts for the period by category of payor (i.e., provision for bad debt and write offs, net of recoveries).

The EITF has re-exposed EITF 09-H and as such, the effective date has not yet been determined.

The proposed standard is in line with anticipated changes in revenue recognition being discussed by the Financial Accounting Standards Board (FASB) and International Accounting Standards Board (IASB). U.S. GAAP has created a very complex, inconsistent set of standards that varies by industry, and conversely International Financial Reporting Standards’ have previously offered very little guidance on revenue recognition. Therefore, the boards are working on a joint project, the essence of which is to create a consistent and concise guide to recognizing revenue. The guiding principle of the joint project is to develop a new standard where “a company should recognize revenue when it transfers goods or services to a customer in the amount of consideration the company expects to receive from the customer.”

Additional guidance and effective dates will be forthcoming, so for now, stay tuned!

ICD-10 Transition Basics

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one reimbursement crosswalk. All ICD-10-CM/PCS codes are in the Reimbursement Mappings; however, all ICD-9-CM codes are not in the Reimbursement Mappings. Where an ICD-10-CM/PCS code translates to more than one ICD-9-CM code, a single choice was made to create a functioning crosswalk. As described by the examples above, a simple one-to-one crosswalk is inadequate to accurately translate ICD-10 coded data to ICD-9 coded data. CMS is not using the ICD-10 Reimbursement Mappings for any purpose. They are converting their systems and applications to accept ICD-10-CM/PCS codes directly.

Additional Resources

CMS Web site
https://www.cms.gov/ICD10/

American Hospital Association (AHA) Web site
http://www.ahacentraloffice.org/ahacentraloffice.shtml/ICD10overview.shtml

Health Information and Management Systems Society (HIMSS) Web site
http://www.himss.org/ASP/topics_FocusDynamic.asp?faid=220

American Health Information Management Association (AHIMA) Web site
http://www.ahima.org/icd10/

National Center on Health Statistics
http://www.cdc.gov/nchs/icd/icd10cm.htm

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Capturing Payment from the Under-Banked

The healthcare industry can learn from a recent development in Silicon Valley. Over the past decade, the world of ecommerce has exploded. Of course, the vast majority of transactions taking place online utilize credit, debit card or stored value cards. A smaller proportion of transactions rely on ACH transaction that draw directly from bank accounts. But if a consumer wanted to conduct a transaction online using cash, that was impossible until recently.

An innovative payment network called PayNearMe (www.paynearme.com) has sprung up to facilitate quick and easy cash payments right in a consumer’s neighborhood at a local store. The concept was originally started to enable gamers who might not have credit or debit cards, to purchase gaming credits using cash. As the concept took hold, it is now enabling consumers to buy products on Amazon.com with cash, an idea that would have been unheard of just a couple of years ago. The company currently enables cash payment for online retailers and other companies through more than 6,200 7-Eleven stores.

The PayNearMe payment process is not as simple as using a credit card or mailing a check, but for those who wish to pay in cash, it is far easier than making a trip back to the merchant in person to pay a bill. By making it faster, less expensive, and more convenient for patients to pay with cash, PayNearMe has the potential to improve collection rates.

For consumers, the process of using PayNearMe is as follows:

1. The consumer receives a printed slip or a PayNearMe card, which represents their balance due.
2. When they are ready to pay for their product or service, they go to a participating 7-Eleven or other merchant and present that slip or card at the register with their cash payment. The slip is scanned or card is swiped, and the payment is accepted.
3. The patient is provided a detailed receipt that can include custom information specific to him or his provider.

The whole process takes less than 60 seconds. In addition to being faster, the process costs the merchant little more than a traditional credit card transaction and certainly less than traditional walk-up bill payment channels, check cashing services or money transfer services.

The applications of a service like PayNearMe for healthcare providers are varied. In the simplest sense, providers can provide the cash payment option as one more way for a patient to address a traditional bill. An option like PayNearMe can also be offered as another way to facilitate online transactions. As healthcare providers create online payment portals, communicating the option to pay in cash, with a clear explanation of how that can be accomplished may appeal to a certain segment of the patient population.

One particularly effective potential application for a service like PayNearMe could be for the management and administration of installment payment plans. As patients go through financial counseling and plans are developed for them to fulfill their financial obligations, overcoming logistical obstacles to the patient paying those installment payments is of paramount importance for compliance with the plan. For patients without the means to pay remotely by check or payment card, having the ability to stop in at a 7-Eleven to pay may be the difference between fulfillment of the payment plan or default.

As the mainstream economy moves further and further toward the ubiquitous use of plastic for transactions, it is easy to forget the importance of cash transaction to a substantial minority of the population. By making the assumption that all patients have the ability to pay their bills by check or payment card, healthcare providers may be missing out on the opportunity to collect from patients who may be willing to pay. In addition to a greater focus on point-of-service collections and more effective financial counseling, finding easy and effective ways to enable subprime patients to pay for medical care in cash can be one part of a solution to the burgeoning problem of self-pay collections.

Gus Bessalel is Managing Director of Co-Pay Funding, LLC, a provider of unique and innovative patient balance payment solutions. He is based in Bethesda, Maryland.
The HFMA Maryland Chapter has many exciting committees that would welcome your participation. If you are interested, please contact the Volunteer Coordinator, Tom Trzcinski, or one of the Committee Chairs below:

<table>
<thead>
<tr>
<th>Committee</th>
<th>Chairperson</th>
<th>Email Address / Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Institute</td>
<td>Charles Zorn</td>
<td><a href="mailto:czorn@mcbllc.com">czorn@mcbllc.com</a> / 410-828-0534</td>
</tr>
<tr>
<td>Community Service</td>
<td>Michelle Brandt</td>
<td><a href="mailto:michelle.brandt@medstar.net">michelle.brandt@medstar.net</a> / 410-933-3015</td>
</tr>
<tr>
<td>Membership</td>
<td>James Case</td>
<td><a href="mailto:jcase@kpmg.com">jcase@kpmg.com</a> / 410-949-8895</td>
</tr>
<tr>
<td>Newsletter</td>
<td>George Bayless</td>
<td><a href="mailto:gbayless@gbmc.org">gbayless@gbmc.org</a> / 443-849-4311</td>
</tr>
<tr>
<td>Website</td>
<td>Brett McConi</td>
<td><a href="mailto:bmcon@kpmg.com">bmcon@kpmg.com</a> / 410-949-8538</td>
</tr>
<tr>
<td>Chapter Education (Program)</td>
<td>Mike Zito</td>
<td><a href="mailto:mazito@kpmg.com">mazito@kpmg.com</a> / 410-949-8444</td>
</tr>
<tr>
<td>Social</td>
<td>Vanessa Smith</td>
<td><a href="mailto:vanessa.o.smith@baml.com">vanessa.o.smith@baml.com</a> / 410-547-4268</td>
</tr>
<tr>
<td>Sponsorship</td>
<td>Keith Persinger</td>
<td><a href="mailto:kpersinger@umm.edu">kpersinger@umm.edu</a> / 410-328-1382</td>
</tr>
<tr>
<td>Volunteer Coordinator</td>
<td>Tom Trzcinski</td>
<td><a href="mailto:ttrzcinski@jhmi.edu">ttrzcinski@jhmi.edu</a> / 410-550-9645</td>
</tr>
<tr>
<td>Certification</td>
<td>Josh Campbell</td>
<td><a href="mailto:joshua.campbell@medstar.net">joshua.campbell@medstar.net</a> / 443-777-7356</td>
</tr>
</tbody>
</table>

**NEWSLETTER COMMITTEE**

George Bayless, Chair  
(410) 849-4311  
gbayless@gbmc.org

Anne Hubbard  
(410) 540-5081  
ahubbard@mhaonline.org

Cathy Zito  
(410) 274-7448  
cmzito@kohlerhc.com

Dan Feeley  
(410) 933-7311  
daniel.m.feeley@medstar.net

Gus Bessalel  
(301) 320-7577  
gus@revenue-cycle.com

Karen Weiss  
(301) 289-3598  
karen.weiss@yesbank.com

Kathryn Crostic  
(410) 328-3864  
kcrostic@umm.edu

Kevin Funk  
(410) 328-5991  
 kfunk@umm.edu

Michael Brozic  
(410) 949-8697  
mbrozic@kpmg.com

Scott Mitchell  
(410) 528-2013  
scott.mitchell@gt.com

Scott Furniss  
(443) 790-5499  
sfurniss@stagnes.org

Shari Wilcoxon  
(410) 822-2399  
swilcoxon@tgarm.com

Liz Sweeney  
(212) 438-2102  
liz_sweeney@standarandpoors.com

Tim Brooks  
(410) 547-4273  
timothy.brooks@baml.com

Hannah Lowe  
(410) 244-4836  
hlowe@mtb.com

Don Kohlhafer  
(410) 547-4278  
donald.kohlhafer@baml.com

Michelle Brandt  
(410) 933-3015  
michelle.brandt@medstar.net

Michael Wertz  
(410) 328-1723  
mwertz@umm.edu

Nancy Creighton  
(410) 543-4759  
nancy.creighton@peninsula.org

Tom Trzcinski  
(410) 550-9645  
ttrzcinski@jhmi.edu

Jim Pisano  
(410) 528-8282  
pisano@assetstrategyconsultants.com

Mitch Lomax  
(410) 368-2926  
mломax@stagnes.org

Jeanette Cross  
(410) 660-9656  
jcross@brg-expert.com

Melissa Pitchford  
(410) 307-6468  
mpitchford@katzabosch.com
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