

**FINAL STAFF REPORT ON THE FINANCIAL CONDITION OF
MARYLAND HOSPITALS**

July 2, 2008

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

FINAL REPORT

BACKGROUND (1988 to 2008)

In addition to achieving the long-standing legislative objectives of cost containment, providing access to hospital care, maintaining equity in hospital prices, and public disclosure, the Commission is directed to concern itself with whether a hospital has the resources to meet its financial requirements. A 1976 Court of Appeals case made clear that the Commission has broad authority over financial affairs of hospitals and directed the Commission to approve only those rates best designed to assure fair costs and fiscal integrity. In 1984, the Court of Appeals found that the HSCRC is not required to guarantee the solvency of a hospital, but is required to set reasonable rates such that if a hospital is operated efficiently and effectively, as determined by the Commission, it will be operated on a solvent basis and will receive fair return on fair value of its assets.

In an attempt to fulfill this responsibility, the HSCRC has periodically reviewed and issued a report on the financial condition of the Maryland Hospital industry. The first such report was in 1988 based on the recommendations of a 1988 Steering Committee consisting of hospital and HSCRC representatives. Subsequently, the Commission regularly published data on the financial condition of Maryland hospitals based on a series of operating, financing, and balance sheet indicators. In 1995, in response to requests by the hospital industry, the HSCRC convened the “Targets Task Force” to evaluate the current set of financial indicators used to assess hospitals’ financial condition. In 2002, following a major “Redesign” of the rate setting system, staff issued a third more comprehensive report. This paper represents the HSCRC’s most recent review of the financial performance and condition of the Maryland hospital industry. It was accomplished by staff with input and support from members of the Financial Conditions Work Group (FCWG). The members of the FCWG are listed in **Appendix 1**.

The following sections summarize the relevant events in this area over the period 1988 -2007.

Original 1988 Steering Committee to Study the Financial Condition of Maryland Hospitals

In the mid to late 1980’s, hospital profitability in Maryland and nationally had eroded partially as a result of rapid increases in nursing costs stemming from a nursing shortage. The HSCRC formalized its annual financial review process in the fall of 1988 when it organized the Steering Committee to examine four major issues:

- The financial condition of Maryland hospitals;
- The reason(s) for the change in the financial condition of hospitals in 1987 and 1989;
- The effect of excess capacity on hospitals’ financial condition; and
- The effect of hospital reorganization (diversification).

Among its recommendations, the Steering Committee identified a series of “parameters whereby the HSCRC could assess the financial performance of the hospital rate system on an on-going basis and determine the extent to which adjustments should be made.” The committee identified seven indicators and target values for evaluating the performance of Maryland’s hospitals both financially and

operationally. The relevant financial indicators and relative targets recommended by the 1988 Steering Committee were as follows:

Table 1
1989 HSCRC Financial Indicators and Target Levels

INDICATOR	DEFINITION	DESIRED TARGET
Operating Margin	$\frac{\text{Tot. Operating Rev.} - \text{Operating Exp.}}{\text{Tot. Operating Revenue}}$	1.75
Total Margin	$\frac{\text{Excess of Tot. Revs. Over Tot. Exp.}}{\text{Tot. Operating Rev.} + \text{Non-Op. Rev.}}$	3.45
Return on Total Assets	$\frac{\text{Excess of Revenue over Expenses}}{\text{Total Assets}}$	3.55
Long-Term Debt to Equity	$\frac{\text{Long-Term Liabilities}}{\text{Fund Balance}}$	0.70
Average Age Of Plant	$\frac{\text{Accumulated Depreciation}}{\text{Depreciation}}$	8 years
FTE per Equivalent Inpatient Admission	$\frac{\text{Full Time Equivalents}}{\text{Equivalent Inpatient Admissions}}$	National Avg.
Cost per Equivalent Inpatient Admission	$\frac{\text{Total Expenses}}{\text{Equivalent Inpatient Admissions}}$	3%-9% below US National Avg.

The purpose of these financial “indicators” and “targets” was to help the Commission evaluate and assess over time the financial condition of the industry collectively. These metrics were intended to be used to inform and assist the Commission in its policy formulation in a general sense; they were not meant to be applied as hard targets or determinants of rate action for individual hospital reviews or for annual system-wide updates. The Steering Committee stressed that indicators must be evaluated in conjunction with each other before conclusions can be drawn as to the industry’s financial condition. No one indicator, financial or operating, was intended to be viewed as dominant. Also, it was recognized that at any time a given ratio might suggest a course of direction counter to the rest of the ratios.

1988 – 1996 Financial Performance

As noted, for subsequent years, the Commission adopted a policy of reviewing the financial performance of the Maryland hospital industry on a regular basis. This policy was adopted in response to the recommendations made by the 1988 HSCRC Steering Committee. Each year from 1989 to 1996, the Commission issued a report on the financial status of Maryland hospitals relative to the targets recommended by the Steering Committee.

During this period also, the Commission adopted a number of policies that reflected its concerns about the financial condition of Maryland facilities. As noted, profitability of Maryland hospitals had eroded during the mid-1980s at a time when Maryland continued to improve on its Medicare Waiver test and in comparisons on cost per adjusted admission with hospitals nationally. In 1989, the Commission approved a 1.5% across the board rate increase to all hospitals related to the additional costs incurred as a result of the nursing shortage. Additionally, the HSCRC's New Service Provision (traditionally a flat annual increment of 1% of revenue granted to each hospital at the time of its annual inflation adjustment) was renegotiated to be based on a three year average of Maryland's cost performance vs. the US. Finally, over the period 1988-1992, the Commission was faced with some 22 full rate reviews, which resulted in average rate increases of approximately 13%. These and other factors increased the rate base of the entire industry over this period.

As a result, from 1988 through 1996, the overall financial condition of hospitals improved considerably relative to historical levels and the pre-established targets. Beginning in 1993, the HSCRC began to witness an erosion in the industry's position both on the Waiver test and in its comparison of cost per adjusted admission vs. the US. This deteriorating cost position, coupled with large increases in "banked" revenue in the system, led to the creation of a Targets' Task Force in November of 1995.¹

1995 Targets Task Force

The focus of the Targets' Task Force was on the establishment of efficiency and expenditure targets that would provide the basis for HSCRC policy changes designed at stemming the system's erosion on cost vs. the rest of the country. The 1995 Targets Task Force made several changes to the indicators established in 1989. First, the Cost per Inpatient Admission target was changed from 3% to 9% below the national average to 8% to 12% below. Secondly, the Long-Term Debt to Equity and FTEs per Equivalent Inpatient Admission indicators were both eliminated. And, finally, the HSCRC began tracking industry performance on the basis of hospital expenditures per capita and admissions per capita.

¹ In the 1980's and 1990's, Maryland hospitals were allowed to forego portions of their annual approved rate increases in a given year, and set these revenues "aside," to be used potentially in future years. The HSCRC referred to these revenues as "banked" revenues (as if they had been stored in a bank and could be made available to hospitals in future years). By the mid-1990's, banked revenue in the Rate Setting System had grown to around \$400 million. This, too, was indicative of the overly generous nature of the rate setting policies during this time.

1998 – 2003 Trends Nationally and In Maryland

The financial condition of hospitals nationally fluctuated primarily in response to changes in both public and private payer reimbursements since 1998 and losses incurred by hospitals from untraditional lines of business. These trends continued in 1999, as the Medicare and private payer payment-to-cost ratios both dropped. These reductions reflected continued pressure on hospitals from both the public and private sectors.

Signs of improvement, however, emerged in the 2000 – 2003 period. Most of this upturn appears to be attributable to hospitals' divesting themselves from money-losing lines of business. During this period, hospitals experienced more favorable Medicare reimbursements (partially restoring some of the payment cuts of the 1997 BBA). At the same time, hospitals became more successful in exerting pricing pressure over managed care.

Given the dramatic reductions in Medicare payments resulting from the enactment of the 1997 Balanced Budget Act, the HSCRC was forced to scale back the annual rate increases granted hospitals from 1999 and 2000. Additionally, with the implementation of the Commission's Rate Redesign in FY 2001, the period FY 2001-2003 was characterized by a more austere rate policy, as the HSCRC continued its efforts to improve both the rate system's position versus the U.S. and on our waiver test.

2000 Rate Redesign Recommendations and 2002 Financial Conditions Report

As noted, the cooperative Rate Redesign effort in 2000 resulted in several changes to the hospital rate setting structure, including better cost controls, simplification of the rate setting system, and the creation of a workable, predictable system for annual rate updates moving forward.

Among its many recommendations, the Redesign Work Group advised the HSCRC to revise and republish its report on financial conditions and the associated financial performance targets in accordance with existing industry trends and financial market standards. It also recommended ways in which the Commission might help improve access to capital for Maryland hospitals. The Redesign Work Group suggested that the HSCRC continue to monitor various indicators of hospital performance year-to-year.

In response to these recommendations, a 2002 Financial Conditions study group was assembled. This study group met for several months, heard testimony from a number of "experts" in the financial services industry, and eventually recommended a revised set of indicators and target levels. The Commission adopted indicators and targets resulting from the 2002 Financial Conditions review. They are presented below alongside the previous 1995 indicators and targets. Notable changes include an increase in the operating and total margin targets, the establishment of a Days of Cash target, and a revision of the Cost Target.

Table 2
Summary of 2002 Indicator Recommendations vs. Previous 1995 Targets Task Force Recommendations

	<u>1995</u>	<u>2002</u>
a) Operating Margin	1.75%	2.75%
b) Excess Margin	3.45%	4.00%
c) Average Age Plant 8.0 years	8.5 years	8.5 years
d) Debt to Cap.	.40	.40
e) Days of Cash (new measure)	N/A	115 days
f) Efficiency Measure Cost/EIPA	8-12% below US	3%-6% below US

Post Rate Redesign and the Three Year Rate Arrangement FY 2004-2006

As noted, the Commission implemented more restrictive rate increases in the period 1999 – 2003. Unfortunately, during this same time period, hospitals both here and nationally experienced unanticipated cost pressures due to increased costs associated with blood products, energy, and nursing labor and other skilled professionals.

Recognizing that many hospitals had been under continued financial constraints during the period 1999 – 2003, the Commission approved a three-year rate agreement that added 2.0% over forecasted cost inflation each of the three years FY 2004, FY 2005, and FY 2006. This added rate relief continued in FY 2007 when the Commission granted an update of approximately 7.0% to Charge per Case (CPC) effective July 1, 2006. In addition to these across the board increases, a number of facilities also received rate increases through the full and partial rate application process. Beginning in FY 2004, the Commission approved a policy that allowed hospitals initiating large capital projects to file for rate relief associated with the increased capital costs they were anticipating. From FY 2004 – 2007, 18 hospitals received rate relief from either full or partial rate reviews.²

As a result of the factors discussed above, Maryland hospitals have experienced a steady improvement in operating performance and balance sheet position, resulting in increased investment in property, plant and equipment particularly, and a corresponding increase in average age of plant. Performance of Maryland hospitals on profit and other financial indicators over the period 1993 -2006 is presented in **Appendix 6**.

² The full and partial rate application process was put on hold during the rate setting system's transition to the use of the All Patient Refined (APR) – DRGs (per the Commission's rate review moratorium from July 2006 through March of 2008).

THE 2008 FINANCIAL CONDITIONS STUDY EFFORT

Purpose of the Current Financial Conditions Work Effort

In the winter of 2007, the Financial Conditions Work Group (FCWG) was assembled to assist staff in performing another review of industry financial condition. Staff first proposed the following purpose statement with input from the Work Group:

Purpose of the Review: To examine and evaluate the current financial condition and operation of Maryland Acute Care Hospitals as both mission-driven and financially-driven institutions. This examination shall occur through considering all factors contributing to this performance, including regulated payment levels, outside sources of funding, access to debt markets, unregulated activities, and operational efficiency and effectiveness. This review should be done in the context of the goal of meeting the Commission's statutory mandate of providing for the full financial requirements of efficient and effective hospitals such that they may operate on a solvent basis with a fair return on investment, all while certifying the hospital costs and rates are reasonable, equitable across all payers of health care, and affordable for the citizens of Maryland.

Reaction of the FCWG to the Proposed Purpose Statement

The proposed purpose statement and analytic approach taken by staff was consistent with the previous Financial Conditions Review, which was praised and supported by all members of the 2002 FCWG. The staff's 2008 analysis solicited input from financial experts in order to understand issues surrounding: 1) the current environment for hospital credit; 2) factors deemed most important when evaluating the credit-worthiness of an issuing institution; 3) factors and circumstances unique to the Maryland environment; and 4) the outlook for the availability of, and cost of, credit in the future.

The staff analysis also documented historical trends in the rate policies of the HSCRC and the financial performance of Maryland hospitals, just as was accomplished in the 2002 Financial Conditions Study when there was considerable concern expressed by the hospitals about the industry's lagging financial performance 1999-2002.

Notwithstanding staff's attempt to follow the approach established in the previous Financial Conditions Review, representatives from the Maryland Hospital Association expressed their "disagreement" with the proposed purpose statement and approach followed by HSCRC staff in conducting this review.

In the MHA view, the financial condition study "*should begin with observation and assessment at a point in time.*" MHA also indicated that the study, "*should conclude as to the relative health of the industry now initially without regard to revenue or expense performance either in the past or in the future.*" Additionally MHA believed the study, "*should refer to national benchmarks such as rating agency ratios.*"

MHA's preferred approach was further described as follows:

[the financial conditions review] is a "balance sheet" focused exercise that then ultimately leads to "P&L" discussion via the negotiation of a rate arrangement (a three-year agreement in recent history). The Financial Condition Study should then project what a healthy industry should look like after a certain period, say five years into the future! This then allows for interim milestones and targets to be set. In other words; in order to get from A to B, certain things need to happen. There needs to be agreement on what both A & B is before being able to discuss the interim steps.

The study should then discuss those operational items which have the potential to significantly impact in future years different than previously experienced. In other words, what could affect "B". In our mind, these would be, for example; physician related expense and other workforce issues, malpractice cost/reform, quality initiatives, community benefits/mission responsibilities and others which we may identify later.

The Financial Condition System then charts a plan for how to achieve the desired outcome through modeling of several options.

While one might conclude that it requires agreement on future rate increases, inflation and productivity; it does not. It calls for outlining potential planning scenarios much like the internal planning documents the hospitals do. Then, the responsibility for delineating the rate arrangement for the future rests with the separate work group assigned for that purpose.

Staff Reaction to the MHA Commentary

Staff was confused by MHA's disagreement with the approach taken by staff in performing the 2008 Financial Conditions Study, given that MHA was highly supportive of this same approach in 2002.

It appeared to staff that MHA's expressed desire to ignore the more recent (and favorable) financial performance of the Maryland hospital industry was in sharp contrast to the MHA approach during the previous Financial Conditions Study, when the lagging financial performance of the hospital industry was the predominant topic of discussion by hospital representatives during the 2002 FCWG meetings. Staff did not find it reasonable and balanced to, on the one hand, focus discussion on historical performance, when the industry had been doing poorly, yet, on the other hand, prohibit the review of historical financial performance, when the industry has been doing quite well relative to historical trends.

Additionally, staff was confused by the language proposed by MHA, which seemed contradictory.

While MHA argued that the current study should take place without reference to historical financial performance, it did argue for an evaluation of the most recent financial performance (which has deteriorated slightly from the historical highs of the FY 2006-2007 period). This also seemed

inconsistent to staff.

While the MHA preferred approach called for the Commission to “*conclude as to the relative health of the industry now initially without regard to revenue or expense performance either in the past or in the future,*” it also recommended the Commission “*should then project what a healthy industry should look like after a certain period, say five years into the future!*”

MHA Proposal Suggests considering Use Bond Agency Medians When Establishing “Benchmarks for Maryland”

Staff believed it was not appropriate from either an analytical or policy perspective to use financial indicators that apply to the top 10% of hospitals nationally as the basis for financial goals and targets for the Maryland hospital industry collectively.

Staff found this suggestion by MHA flawed both from an operational and policy perspective.

The approach is operationally flawed, because hospital spending is highly influenced by the generosity of rate increases year-to-year. Setting Bond Rating Agency medians as industry wide targets would require higher annual rate increases (in excess of the generous add-ons to rates in the 2004-2007 period). Because hospital spending increases as hospital rates are raised, the HSCRC would have to infuse even more revenue into the system to fund both the increased expenditure levels, while at the same time, allow the industry to hit financial targets that apply to the top 5% of hospitals nationally. The more money it infused into the system to the unrepresentatively high financial performance results of investment grade hospitals nationally, the greater Maryland hospital spending would be, and the more the Commission would have to increase rates to meet the unrealistically high targets.

While the use of bond rating medians for the top 5% of U.S. hospitals is not appropriate as a set of benchmarks for the system as a whole, staff believes that rating agency medians may be useful; however, analysis of these medians should be in the context of what they represent – the financial performance of the top 10% of all hospitals nationally. Continuing with this logic, a payer representative on the FCWG suggested using the bond agency medians on a “stratified basis – comparing the same financial indicators of Maryland’s top performing hospitals (the investment grade facilities – of which it has been reported that Maryland has a higher percentage than a majority of other states).

Given the points above, staff defaulted in this review to the same approach that resulted in the HSCRC’s successful and well-received 2002 Financial Conditions Review. The following report contains analysis and discussion similar to what was presented in 2002.

Background on Hospital Access to Capital

Non-profit hospitals derive their capital for investment from both internal sources, such as operating cash flow, and external sources, such as debt, charitable contributions, and grants. Unlike the for-profit sector, non-profits cannot raise equity funds in the capital markets, but have to rely on historical profits and cash flow and philanthropy for equity capital investments. In order to access the tax-exempt markets at reasonable rates, hospitals must demonstrate sufficient credit worthiness to receive investment grade ratings or obtain some form of credit enhancement (usually either municipal bond insurance or letters of credit) permitting the sale of the bonds.³ Bond rating agencies determine creditworthiness of non-profit hospitals principally by evaluating the ratio of anticipated cash flow to annual debt service, the proportion of debt in the hospital's capital structure, and the level of cash balances.⁴ In periods of financial stress, rating agencies and investors generally require higher debt service coverage ratios and cash reserves and lower debt to capitalization ratios in order to assign investment grade ratings and underwrite hospital credits.

The market for hospital bonds rated below investment grade is extremely limited. Most bond funds will not purchase issues rated below investment grade, and brokers are restricted in their ability to sell bonds rated below investment grade to individual investors under the Securities and Exchange Commission's suitability rules. High yield bond funds become one of the few sources of investment capital for below investment grade hospitals, and they demand a very high return on invested capital.

While an investment grade rating is required for access to the public capital markets, in practice, hospitals with credit ratings in the lower tier (Baa for Moody's, BBB for Standard and Poors, and Fitch IBCA) have more limited access to capital. The reason for this is that most municipal bond funds are limited in their ability to purchase bonds rated below A. Furthermore, credit enhancement in the form of municipal bond insurance has historically been less available to hospitals whose bond rating is below A. The availability of letters of credit as credit enhancement has also been more limited in these circumstances.

Some smaller hospitals in rural counties have obtained access to debt capital by participating in their county's general obligation debt offerings. The mechanism for such a borrowing is as follows: the county includes its hospital's capital needs in a county bond offering. The proceeds are then loaned to the hospital on a pass through basis by the county. The rating agencies count this additional debt as

³ Bond insurance represents a legal commitment of a municipal bond insurance company to make timely payments of principal and interest in the event that the hospital is unable to do so. The insurance policy generally provides that, in the event of default by the hospital, debt service payments will be made as originally scheduled. Commercial banks issue letters of credit that guaranty the timely payment of debt service on hospital bonds. Unlike bond insurances, letters of credit generally are issued for three to five year terms and seldom extend beyond a ten-year term.

⁴ The three dominant municipal bond rating agencies are Moody's Investors Services, Inc., Standard and Poor's Ratings Services, and Fitch IBCA. All three rate long term bonds, short term obligations, and obligations secured by insurance, bank letters of credit, and other credit enhancements issued by or on behalf of hospitals. The investment rating categories are as follows: Moody's: Baa, A Aa, Aaa; Fitch/IBCA and Standard and Poors: BBB, A, AA and AAA, with Aaa and AAA having the highest rating categories.

county debt, which limits the county's debt capacity, a factor that has led certain counties to encourage their hospitals to borrow on their own credit and not limit the county's ability to finance future county infrastructure.

Recent Credit Market Activity

Following a period characterized by reduced federal and private sector reimbursements nationally (from 1998 – 2003), hospitals in the rest of the U.S. have generally seen an improvement in payment levels and profitability since 2003. These circumstances facilitated what turned out to be the largest period of recapitalization for the hospital industry since the wave of hospital construction and recapitalization in the late 1970s and early 1980s. As a result of cost constraint on the part of Maryland hospitals and additional discretionary funding granted by the Commission through the annual rate updates FY 2004-2006, Maryland hospitals also improved profitability and cash flow over this period. This improvement in financial condition, coupled with hospitals' growing need to recapitalize (due to such factors as aging plants, consumerism, quality and safety initiatives, competitive pressures) and favorable credit access resulted in large increases in credit market activity by Maryland hospitals (FY 2004 to the present).

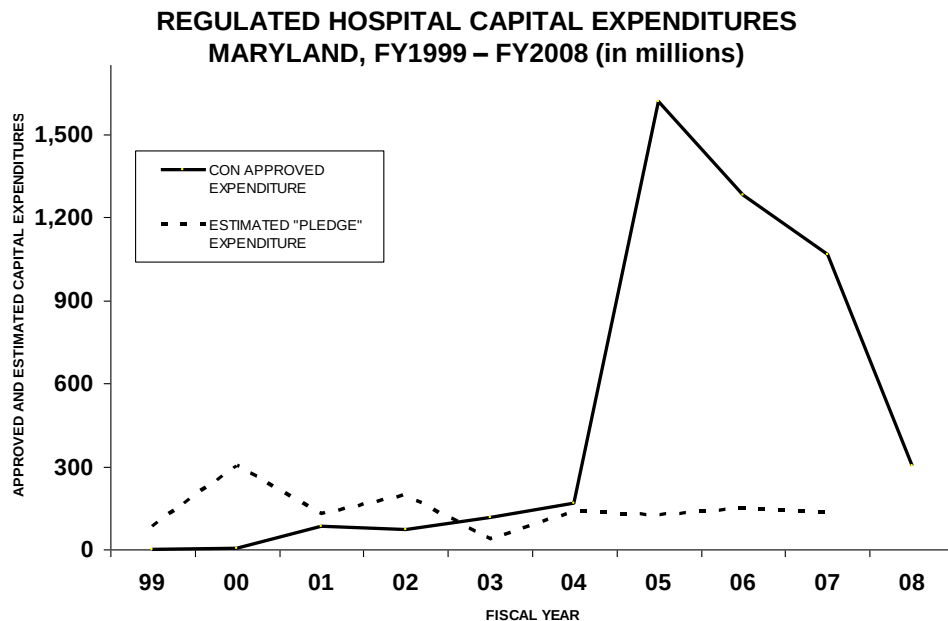
Maryland Recapitalization Effort

Since 2003, Maryland hospitals have been engaged in an effort to recapitalize and replace aging facilities and upgrade operations with investments in new technologies and health information systems. Over the period 2003-2008, Maryland hospitals submitted Certificate of Need (CON) and CON exemption applications to the Maryland Health Care Commission for projects in excess of \$5.0 billion. Table 3 provides a summary of recapitalization project requests for the years 2003 – 2008.

Table 3
Approved CON Projects and "Pledge" Projects

	2003	2004	2005	2006	2007	YTD 2008	Totals 2003 - 2008 YTD
CON Approved	\$116,091,176	\$166,170,554	\$1,618,421,360	\$1,281,810,642	\$1,064,596,339		\$4,247,090,071
Pledge	\$37,594,400	\$135,503,200	\$122,402,575	\$146,909,916	\$132,712,042	\$301,555,726	\$876,677,859
							\$5,123,767,930

Chart 1
Approved CON Projects and “Pledge” Projects



SOURCE: MHCC

This recapitalization effort was facilitated by two factors: 1) more favorable credit market conditions during the period 2004-2007; and 2) rate relief granted by the HSCRC in the form of 2.0% add-ons to the annual rate update for each of the three years FY 2004 – 2007 and amounts granted to hospitals filing full and partial rate applications during this same period. All in all, between 2003 and 2008, 36 of the State’s 47 general acute care hospitals have applied for CON-related approval or “Pledge” projects for major capital projects.⁵

Difficulties in the Credit Markets 2007-2008

After a prolonged period of highly favorable credit market conditions and lower than historical cost of capital, the credit markets have most recently experienced considerable tightening following the crisis in the subprime mortgage market. The subprime crisis is an ongoing economic problem manifesting itself through liquidity issues in the global banking system, resulting from foreclosures that accelerated in the United States in late 2006 and triggered a global financial crisis during 2007 and 2008. Mortgage

⁵ So-called “Pledge” projects are capital projects for which a hospital may receive an exemption to the CON approval requirement if the hospital “pledges” not to seek a rate increase associated with this project.

lenders retaining credit risk (the risk of payment default) were the first to be affected, as borrowers became unable or unwilling to make payments. Over time, other financial institutions (including investment banks, real estate investment trusts (REITs), and hedge funds) around the world have reported losses in excess of \$350 billion as of May, 2008.

With the emergence of a form of financial engineering called securitization, many mortgage lenders passed the rights to the mortgage payments and related credit/default risk to third-party investors via mortgage-backed securities (MBS) and collateralized debt obligations (CDO). During this crisis, corporate, individual, and institutional investors holding MBS or CDO faced significant losses, as the value of the underlying mortgage assets declined.

A secondary cause and effect of the crisis relates to the role of municipal bond "monoline" insurance corporations such as Ambac and MBIA. Hospitals and other institutions issuing debt in the Municipal Bond market can purchase insurance (against default) from bond insurers and thereby achieve higher debt ratings. However, these insurers invested heavily in CDOs and have also suffered significant losses. These losses brought their ability to insure bonds into question and eventually resulted in rating downgrades of these particular bond insurers. A ripple effect of this circumstance was a downgrading of the bonds these monolines insured or guaranteed. In turn, this may require financial institutions holding the bonds to lower their valuation or to sell them, as some entities (such as pension funds) are only allowed to hold the highest-grade bonds. The effect of such a devaluation on institutional investors and corporations holding the bonds (including major banks) has been estimated as high as \$200 billion. Regulators are taking action to encourage banks to lend the required capital to certain monoline insurers, to avoid such an impact; however, in the short term, the deterioration of municipal bond insurers and the issues they have insured have had a ripple effect in the overall market for municipal bonds. This impact has been felt most significantly in the market for Auction Rate Securities (ARS) and Variable Rate Demand Obligations (VRDO). An in-depth discussion of the current disruption in the market for Auction Rate Securities (a situation that has implications for Maryland hospitals who attempted to "lock-in" more favorable short term interest rates through variable rate "swap" arrangements, is discussed in **Appendix 4** to this document.

DISCUSSIONS WITH OUTSIDE EXPERTS

Interviews with Representatives from the Credit Markets

Early in the Work Group's discussions regarding hospital financial condition and performance, it was suggested that HSCRC staff solicit the input of representatives from individuals directly involved in evaluating hospital credits, bond rating agencies, bond insurers, commercial banks, and institutional investors. Staff also suggested contacting individuals with some experience and expertise regarding operational efficiency and the most current information on national hospital trends. A list of the individuals interviewed is presented in **Appendix 3**.

During the course of several months, the Work Group interviewed 15 outside advisors in person or via conference call. The input from these individuals provided the Work Group with a good sense of how

Maryland hospitals are viewed by the credit markets and helped supplement our knowledge regarding such topics as: a) factors taken into consideration when evaluating the credit-worthiness of a particular institution; b) factors that differentiate Maryland hospitals from hospitals nationally; and c) an assessment of the current credit market environment nationally and issues affecting the availability and cost of credit to hospitals in Maryland and nationally. Additionally, the FCWG interviewed one expert in the area of hospital productivity improvement. Those interviewed also provided comments regarding the prospects for hospitals' access to the credit markets now and in the future.

The following points summarize and highlight the input received from the outside advisors interviewed by the Financial Conditions Work Group:

General Factors Taken into Consideration when Evaluating Credit-Worthiness

The rating factors most often cited by the advisors were organized into six distinct groups: 1) quality of management; 2) characteristics of market or service area; 3) characteristics of the medical staff; 4) level of strategic planning; 5) capital needs relative to debt capacity; and 6) stable and favorable financial performance. Several advisors indicated that a few of these factors (succession planning, demographics, and physician/hospital alignment) were becoming increasingly important.

Rating agencies generally look for proactive management with a mix of new and tenured members who are able to articulate and implement linked capital and strategic plans. On the financial side, balance sheet indicators, such as liquidity and debt service coverage, were most important for credit considerations because they indicate how well a hospital might be able to survive difficult financial conditions. Of equal importance was stability of operating earnings over time.

Uniqueness of Maryland

As was the case during the 2002 discussions with outside experts, all of the advisors interviewed for the 2008 study cited rate regulation of hospitals as a key differentiating factor for the State in terms of their credit review.

The positive features of rate setting were seen as additional financial stability for hospitals and protection and insulation of Maryland hospitals from year to year changes in private and public payer reimbursement policies.

Some advisors compared Maryland acute care hospitals to national hospitals on a variety of financial measures. They noted that although the median for Maryland hospitals on these measures was often lower than the national median, Maryland hospitals were given more favorable ratings due to the stabilizing effect of the rate setting methodology and other intangible aspects of Maryland's healthcare system.

One advisor noted that the rate setting methodology in Maryland has produced an "artificial floor" below which few hospitals fall. Accordingly, there is only one speculative grade hospital in Maryland,

while the median rating for Maryland hospitals was the same as the national median, i.e., A3. It was further explained that across a variety of financial measures, Maryland hospitals were trending favorably. Maryland hospitals have, historically, lagged behind the national medians but seem to be closing the gap.

Other positive considerations cited about Maryland included the following: demographics (i.e., affluence and growth), economic stability, strong clinical affiliations, investment level, and rate predictability (i.e., stability). One advisor added that the proactive management of environmental influences (nursing shortages, pay-for-performance methodology) and the HSCRC's resources are a positive credit factor for Maryland hospitals. It was also noted that some institutional investors view the Commission's interventions positively and, in recognition of this, market participants have historically given up 10-15 basis points per bond (more favorable cost of capital due to lower levels of uncertainty in the State). One advisor added, however, that the current credit environment has altered this picture, and this no longer holds true. In general, the Maryland rate system was praised for its "openness and transparency."

When asked whether national trends regarding the supply of nurses and allied health professionals might have an effect on the credit environment, one advisor replied that hospitals have adapted to the nursing shortage by investing in information technology to better track and adjust staffing levels. He added that in Maryland, the strong relationship between hospitals and colleges appeared to have minimized agency expense relative to hospitals in other states.

Negative observations regarding Maryland included overly competitive markets in some areas, price constraints, "thinner balance sheet resources," a heavily consolidated payer environment, disconnects between rate-regulated and unregulated providers, confusion about the regulatory environment, and recent rate activity. Most advisors believed the HSCRC's mid-year adjustment of reimbursement rates created some uncertainty and anxiety amongst providers and investors in the capital market. They stressed, however, that it was the uncertainty, rather than the magnitude of the rate cut, that caused the anxiety.

When asked whether physician shortages were unique to Maryland, several advisors replied that there were physician shortages nationwide and described a few of the initiatives taken to ameliorate the effects.

Elaborating on the issue of "thinner" balance sheets of Maryland hospitals, one advisor responded that it was his perspective that the rate setting system had a moderating effect on the market, producing fewer high performance hospitals as well as fewer low performance hospitals. He added that in a freer market environment some hospitals might rise to a AA rating, but some hospitals would certainly fall in terms of ratings.

The presence of the Maryland Bond Indemnification program (the program in State law that authorizes the HSCRC to defease the public body obligations of closed or de-licensed hospitals) was viewed favorably, but not significant enough to merit a positive rating adjustment for Maryland hospitals.

Some advisors voiced concern about the short to medium term financial implications on the hospital industry in Maryland of any push for deregulation.

Issues Currently Affecting Credit Availability and Cost

From 2004 – 2007, hospital bond issuance grew substantially, with the greatest increases in un-enhanced issuance (bonds issued with bond insurance or backed by bank letters of credit). In 2007, bond insurers backed off on the par amount they were willing to underwrite, and more un-enhanced hospital issuance came to market. Hospital issuers used these conditions to restructure debt at extremely attractive rates.

In 2008 and beyond, the advisors anticipate that the proportion of un-enhanced issuance will continue to grow (as noted previously, several high profile bond insurers were downgraded after sustaining substantial losses on Collateralized Debt Obligations). The level of absolute issuance should also moderate over the next few years, although the healthcare sector's ongoing recapitalization effort should keep issuance relatively strong.

Some advisors believed that despite some recent turmoil, credit was available to hospitals at good terms, noting that recent activity in the sub-prime housing market had not had much direct effect on the availability of credit for hospitals. These advisors foresaw a continuation of the favorable 2007 healthcare credit environment through 2008. It was noted that declines in the equity markets would erode investment returns, yet bond rating agencies tend to discount the impact of year to year fluctuations in investment performance when establishing ratings for hospitals. Advisors interviewed later in the process expressed more concern about the credit markets citing disruptions in the market for auction rate securities (described above).

Ability of Hospitals to Generate Productivity Improvements

One topic not thoroughly explored in the last Financial Conditions Review related to the issue of the potential for productivity gains by hospitals. Increasingly, first and third party payers, weary of continual increases in health expenditures (both absolute and relative to total income levels), have been calling for increases in the value of the health care product they purchase.

The Commission has always included one productivity measure in its list of financial indicators (that of hospital cost per Equivalent Inpatient Admission – Maryland position vs. U.S. position). Because of the increased concern regarding the overall affordability of hospital services, the staff invited Jack Ashby, a former analyst for the Medicare Prospective Payment Commission (MedPAC), to present his perspective on the ability of hospitals (both in the past and in the future) to generate productivity gains.

Mr. Ashby began his discussion by describing MedPAC's position on measuring productivity improvement and noted that MedPAC believes that hospitals should be expected to improve productivity by a modest amount each year with no cost to quality. He also noted that as market competition demands constant productivity improvement in the private sector, Medicare should demand the same.

Mr. Ashby continued by stating that MedPAC's efforts to measure productivity improvement began over 15 years ago. He explained that any measure of productivity needs to include inputs and outputs

with quality held constant. MedPAC's first efforts at measuring productivity were directed towards labor productivity and examined occupation-mix adjusted labor hours relative to real case-mix adjusted and outpatient adjusted admissions. Mr. Ashby noted that it was important to parse out case-mix increases due to improvements in coding from real changes in case mix. Using this measure, MedPAC determined that there were real productivity increases only during the first two years of PPS.

Next, Mr. Ashby described the second phase of MedPAC's efforts to measure productivity improvement. During the 1990's, MedPAC observed that limiting inputs to labor inputs excluded important information about capital costs, since many improvements in productivity are due to substituting capital for labor. MedPAC then began to measure productivity improvement as a function of cost per case deflated by market basket (operating and capital). MedPAC also developed an alternative, and more controversial, measure of productivity, by taking aggregate productivity (cost-deflated, real case-mix adjusted admissions) as a function of productivity for individual services and intensity of services per admission. Using this measure, MedPAC determined that during the late 1980's and early 1990's, hospitals were improving productivity in services, but these improvements negated by increases in the intensity of services. Later in the 1990's, service intensity decreased, while productivity for individual services remained constant. Mr. Ashby noted that at the end of the decade, MedPAC lost the ability to measure the intensity of services because the CPI measure based on charges was altered in ways that made it unsuitable to calculate service intensity. When asked whether there will be more of an emphasis on productivity as Medicare faces increased threats to its budget and trust fund, Mr. Ashby replied that he believes that this will be the case.

Mr. Ashby noted that productivity increase measurement is problematic today, because it is difficult to forecast market basket changes. Additionally, it has become more difficult to parse out real vs. recoded case-mix increases. Mr. Ashby concluded by stating that it is still MedPAC's conviction that hospitals should be able to increase productivity if productivity is increasing in the rest of the economy. He noted, however, that whether service industries can increase productivity at the same rate as manufacturing is still a topic of some debate.

Future Prospects for the Credit Markets

Looking to 2009 and future years, the advisors stated that health care reform, economic recession, and fiscal shortfalls at the state level may begin to have a negative impact on the credit environment for hospitals. Six factors that will drive down hospital financial performance over the next several years were identified as: 1) the moderation of Medicare reimbursement; 2) the growing importance of P4P reimbursement; 3) greater scrutiny of charity care policies; 4) growing budgetary concerns including employee benefits, supplies, and bad debts; 5) growing capital expenditures related to electronic medical records systems; and 6) inconsistent patient volume trends due to self-rationing of healthcare.

The advisors stressed that Medicare reimbursement is likely to decrease, and that changes in payment structure and payer concentration are likely to drive down commercial reimbursement. Additionally, investment portfolios and debts structures within the industry were becoming riskier, physician shortages were becoming more acute, and hospitals were likely to face increasing scrutiny from both public and private "watchdogs." Nursing shortages were likely to intensify with the physician shortages,

although both would apply to predominantly rural markets.

As far as the credit markets were concerned, there was a general consensus that the future market for municipal bonds will be much more “credit-driven,” and that credit risk assessment will play a more important role with a focus on credit rating, as well as future rating direction, momentum, and “rating resiliency.” Changes in the supply and demand of credit for hospitals are likely to result in further spread widening. Despite these less favorable trends, many still believed that credit would still be widely available to hospitals with stable and favorable operating performance. In the future, a more “credit-driven” environment will exact higher yields and wider spreads that are more commensurate with a hospital’s credit risk profile. Although the industry as a whole will see leaner balance sheets, hospitals nationally should remain relatively stable due to high levels of liquidity.

General Points

The environment for the availability of hospital credit has been quite favorable in recent years, although we have witnessed tightening in the credit markets due to the crisis in the subprime mortgage market. The most deleterious impact of this crisis has been the downgrading of several high profile bond insurers and the impact of these downgrades on the market for variable rate swaps. The absence of the ability to realize historically lower cost of capital through the use of swap arrangements may mean additional financing costs and a return to the historically higher long term interest rates experienced by hospitals before 2004.

Rate setting in Maryland is generally viewed as a positive feature in the analysis of hospital credits. The stability and increased predictability associated with rate setting tends to offset any negative associated with “thinner” balance sheets generally experienced by Maryland hospitals.

Maryland appears to have improved its position on overall capitalization versus the U.S. considerably during the period 2003-2008 as a result of the investment in Property, Plant and Equipment (PP&E) – including information systems - stimulated by favorable borrowing conditions, higher hospital rates, and high volume growth during this period.

Maryland may be slightly disadvantaged by lower levels of liquidity and higher debt. As noted, the stability of the rate system and the tendency to have more consistent earnings year-to-year counter-balance this to a degree. However, given the high proportion of investment grade rated hospitals in the State and the general comments of the advisors, it is staff’s perception that the relative access to capital and the cost of debt capital here have been better than in the rest of the nation (2003-2008). It remains to be seen however, as to whether this trend will continue in the future.

Given Maryland and US hospitals’ relatively poor cost performance in recent years, there will likely be increased attention to focused on the topics of hospital productivity improvement and enhanced value of hospital care in the coming years. An overall objective of the HSCRC and the payer and hospital industries should be to support the continuation of the more favorable financial performance experienced in recent years through a combination of reasonable rate increases and productivity improvements moving forward.

Current Financial Condition of the Maryland Industry

Factors Contributing to the Decline in Hospital Profitability

In performing the review of the Financial Condition of the Maryland hospital industry the FCWG noted that profitability of the industry appears to have declined from fiscal year (FY) ending 2007 to year to date FY 2008. HSCRC F/S data covering the first nine months of the current fiscal year show both regulated and unregulated operating profits declining to 2.15% from 2.73% for the first nine months of FY 2007. Year end FY 2007 operating profit (of 2.76%) was consistent with nine month YTD 2007 performance (see **Appendix 7**).

While some of this decline may be a result of higher than expected increases in inflation and intensity, other factors may well be accounting for the reported deterioration:

- 1) Undercharging: Analysis of rate compliance for this period showed an approximate 0.4% undercharge that will be “made up” the balance of this fiscal year. Staff acknowledges that some of these undercharges may well have already been “booked” by the hospitals (reflected on reported profit and loss statements); however, the pattern of undercharging in the fall and winter accompanied by offsetting overcharges in the spring and early summer, may have been based on the expectation of implementation of the HSCRC’s outpatient CPV constraint system in FY 2008 (hospitals may have cautiously undercharged prior to knowing their CPV targets);
- 2) Volume declines at four Hospitals and likely Targeted Rate Relief: Further analysis of the regulated and unregulated operating profit performance of the industry shows that four facilities are driving the majority of the deterioration in profits from 2007 to 2008, primarily due to large volume declines. Staff recognizes that due to the transition to the application of a volume adjustment in 2009, the Commission will likely need to address these circumstances separately. When removing these hospitals from the analysis, industry profitability appears to be approximately 2.8% for FY 2009. When adding back an expected net undercharge from the first part of FY 2008 of 0.2% is put back into the system, staff expects the final regulated and unregulated operating profits to be closer to 3.0%.

It should be noted that with the lifting of the moratorium on full rate reviews, the Commission recently received full review applications from three hospitals with rate requests in excess of \$50 million. Staff does not anticipate recommending this magnitude of increase to be granted, however the full review applications, anticipated partial rate applications and targeted relief to hospitals experiencing large volume declines as the Commission transitions to the volume adjustment in 2009 are expected to provide rate relief for facilities most in need. Accordingly, while reported operating profits have declined, staff believes that the final operating profits for hospitals for FY 2008 should more closely approximate the operating experience of FY 2007 (which were right at Commission operating profit target levels).

FINAL RECOMMENDATIONS

Financial Indicators and Ratios – Report of the FCWG Data Subcommittee and Staff Recommendations

In fulfillment of one of its statutory mandates, the Health Services Cost Review Commission reviews and evaluates the financial condition of the Maryland hospital industry. In carrying out this evaluation, it reviews industry performance based on a group of selected ratios and indicators to overall preferred industry target values. It should be emphasized that this evaluation is limited to aggregate industry oversight and cannot be applied at an individual hospital level since assessing the overall financial health and determining an individual hospital's ability to access the lending market, in order to recapitalize, is not as simple as reviewing a few financial indicators and ratios.

The Financial Condition Report currently includes the medium Operating Margin, Excess Margin, and Cost per EIPA as measures of operating profitability and efficiency. It includes Debt to Capitalization, Days of Cash on Hand, and Age of Plant as measures of balance sheet strength. However, it does not include any measure of cash generated through operations, even though cash is extremely important to bond purchasers and lenders. Additionally, balance sheet data currently used in the report only includes those data that are reported as part of the hospital entity itself. As hospitals have become just one entity within a healthcare system, data from other related entities, including the parent or its endowment fund, are not included, even though they are included as part of the obligated group when borrowing. For instance, some hospitals report no cash or debt on their own statements, while others report only certain types of cash on their statements, while the remainder is reported at the system level. Finally, Age of Plant can be confusing as hospitals are forced to write off the remaining useful life of an asset scheduled for retirement or carry the depreciation of an asset that is no longer used but still included on their books.

In order to strengthen the meaningfulness of the report, the staff recommends the following changes:

- 1) The report should include some measure of an operations ability to generate cash. Staff recommends using Earnings Before Interest Depreciation Taxes and Amortization (EBIDTA) Ratio, which represents cash generated by operations before consideration of capital purchases, financing activities, and investing activities. The ratio can be presented as a percentage of net operating revenue. If capital expenditures are expected to be 8%, and the target operating profit is 2.75%, then the EBIDTA target should be set at 10.75%. Staff may also recommend reporting Debt Service Coverage Ratio, which represents the industry's ability to cover its debt service (principal and interest) with cash generated from operations. A reasonable target value would be less than the national average since the operating profit target is less than the national average. The U.S. averages over the last 5 years are 3.04 times in 2002, 3.20 times in 2003, 3.45 times in 2004, 3.91 times in 2005, and 3.79 times in 2006. Staff believes a reasonable target is 3.0 times.
- 2) Staff believes that the reported balance sheet indicators are reasonable and does not

recommend any additional measures. However, as noted above, staff believes that additional data are needed in order to ascertain the true strength of balance sheets used when hospitals are accessing the capital lending markets. Therefore, staff recommends that all hospitals provide to the Commission, on an annual basis, the data necessary to calculate Days of Cash on Hand and Debt to Capitalization as reported to bond holders and lenders for the “Obligated Group.”⁶ The data should be audited and based on the hospital’s fiscal year end. It should be reported to the Commission no later than 120 days after the end of the hospital’s fiscal year. Average Age of Plant should continue to be reported each year. However, the results may need to be further scrutinized in order to ascertain its true meaning.

3) Cost per EIPA currently includes a range from 3% below the national average to 6% below the national average. The payer representatives believe that the target value should be a fixed level as opposed to a range. However, this target should take into consideration where the Commission expects revenue per case to be and its target value for operating margin. Staff recommends deferring consideration of this target pending completion of further analysis and review of the EIPA statistic as well as Maryland and U.S. trends affecting the calculation of that statistic.

Recommended Indicators and Target Levels:

- 1) **Operating Margin:** Staff recommends maintaining the operating margin target at 2.75%.
- 2) **Excess Margin:** Staff recommends maintaining the excess margin target at 4.0%.
- 3) **Average Age of Plant:** Staff believes that the average age of plant target of 8.0 years should be maintained.
- 4) **Debt to Capitalization:** Staff recommends maintaining the current target level for Long Term Debt to total hospital Capitalization of 0.40.
- 5) **Cash Target:** Staff recommends maintaining the current Commission target of 115 days. Staff additionally recommends that all hospitals provide to the Commission, on an annual basis, the data necessary to calculate Days of Cash on Hand and Debt to Capitalization as reported to bond holders and lenders for the “Obligated Group.”
- 6) **Efficiency Target:** Staff defers its recommendation regarding the target of hospital cost per Equivalent Inpatient Admission (EIPA) vs. the U.S. of 3.0% to 6.0% below the nation pending further analysis regarding the calculation of the EIPA statistic based on trends in

⁶ The Obligated Group includes those entities within a healthcare system whose assets will be responsible for repaying the hospital’s debt.

Maryland and nationally. Staff anticipates this analysis will be completed early this summer.

- 7) **EBIDTA Ratio:** Staff recommends the inclusion of an Earnings Before Interest Depreciation Taxes and Amortization (EBIDTA) Ratio, which represents cash generated by operations before consideration of capital purchases, financing activities, and investing activities. The suggested target level is 10.75% of net operating revenue.
- 8) **Debt Service Coverage Ratio:** Staff recommends the inclusion of a Debt Service Coverage Ratio (DSC Ratio), which represents the industry's ability to cover its debt service (principal and interest) with cash generated from operations. The suggested target level is 3.0.

Summary of Staff Indicator Recommendations and Alternative Views:

a) Operating Margin	2.75%
b) Excess Margin	4.0%
c) Average Age Plant	8.0 years
d) Debt to Cap.	.40
e) Days of Cash	115 days
f) Efficiency	Deferred
g) EBIDTA Ratio:	10.75%
h) Debt Service Coverage Ratio:	3.0

Appendix 1 – Performance on Financial Indicators

Operating and Total (Excess) Profits Maryland vs. U.S. 1993-2007

Year	Maryland					U.S.			
	Audited Financials ¹		MHA Data Submitted to AHA ^{2**}		HSCRC Regulated ³	AHA Data ^{4**}		Colorado Data Bank ⁵	
	Operating Profit	Excess Profit	Operating Profit	Excess Profit	Operating Profit	Operating Profit	Excess Profit	Operating Profit	Excess Profit
1993	2.88%	2.59%	1.98%	2.84%	2.91%	2.51%	4.23%	N/A	N/A
1994	3.35%	2.83%	3.13%	3.89%	3.91%	3.35%	4.76%	N/A	N/A
1995	4.43%	5.28%	4.32%	5.51%	5.53%	3.87%	5.63%	N/A	N/A
1996	4.41%	5.13%	4.23%	5.47%	5.97%	4.55%	6.75%	N/A	N/A
1997	4.04%	5.44%	3.40%	5.09%	6.20%	3.08%	6.68%	N/A	N/A
1998	2.40%	3.60%	2.81%	4.62%	4.41%	2.08%	5.75%	N/A	N/A
1999	1.10%	2.30%	0.79%	2.26%	4.29%	2.03%	4.65%	N/A	N/A
2000	0.80%	2.50%	1.00%	2.50%	2.66%	2.49%	4.56%	N/A	N/A
2001	1.40%	2.10%	2.49%	3.14%	2.85%	2.50%	4.23%	2.80%	4.80%
2002	2.00%	2.40%	1.68%	2.00%	3.50%	3.35%	4.27%	3.20%	4.50%
2003	1.70%	2.30%	1.98%	2.60%	3.54%	3.33%	4.61%	2.50%	4.00%
2004	2.54%	2.90%	2.62%	3.58%	4.51%	3.46%	5.02%	3.00%	5.40%
2005	3.20%	3.81%	3.04%	4.30%	4.91%	3.66%	5.25%	3.80%	5.80%
2006	3.39%	4.14%	3.08%	4.58%	5.01%	3.61%	5.51%	4.30%	7.00%
2007	N/A	N/A	3.27%	5.49%	N/A	N/A	N/A	4.30%	8.30%

¹Source: HSCRC Audited Financial Reports

²Source: Data submitted to the AHA from MHA

³Source: HSCRC Disclosure Reports;

⁴Source: AHA

⁵Source: Colorado Hospital Data Bank

* Includes unregulated Activities

** For 1993-2001 – Total hospitals including Nursing Home Unit (U.S. Not adjusted for fiscal years). For 2002-207

– Adjusted AHA Data

Appendix 2 - Financial Conditions Work Group Members

Name	Title	Affiliation
Robert Murray	Executive Director	HSCRC
Tricia Roddy	Director of Planning	DHMH
Paul Sokolowski	Sr. VP.	Maryland Hospital Assoc.
Bob Brubeck	CFO	Marylad Hospital Assoc.
Ron Werthman	CFO	John Hopkins
John O'Brien	Deputy Director – Methodology	HSCRC
Ellen Englert	Assoc. Director – Hospital Reg.	HSCRC
Jerry Smith	Deputy Director – Hospital Reg.	HSCRC
Dennis Phelps	Assoc. Director – Audit and Compliance	HSCRC
Hal Cohen	Consultant	CARE First/Kaiser Permanente
Michael Curran	CFO	Medstar
Chuck Orlando	CFO	LifeBridge Health Manangement
Paul Parker	Chief, Hospital Services Policy & Planning	MHCC
Harvey Litman	CFO	United Healthcare
Annette Anselmi	Exec. Director	MHHEFA
Greg Vasas	CareFirst	
Ray Grahe	CFO	Washington County Health System
Michael Curran	CFO	Medstar
Robb Cohen	Chief of Cog. Affairs Office	XL Health
Marty Basso	Senior VP of Finance	Suburban Hospital
Stuart Erdman	Sr. Director of Finance	John Hopkins

Appendix 3 – List of Financial Experts Interviewed by the FCWG

Jeff Schaub	Senior Director, Public Finance	Fitch Ratings
Carolyn Tain	Senior Director	Fitch Ratings
Beth I. Wexler	VP/SCO	Moody's Investor Services
Mark Pascaris	AVP	Moody's Investor Services
Dan Steingart	Analyst	Moody's Investor Services
Don Kohlhafer	Senior VP	Bank of America
Bruce Gordon	First VP	Ambac Assurance
Steve Renn	Head of Healthcare Underwriting	Ambac Assurance
Dean Scarano	Healthcare Underwriting	Ambac Assurance
Jim Mullins	Healthcare Underwriting	Ambac Assurance
Steve Rochford	Head of Healthcare Risk Management	Ambac Assurance
Eleanor Matthews	Healthcare Risk Management	Ambac Assurance
Lilly Scher	VP	Eaton Vance
Marcy Lash	VP	T. Rowe Price Associates
Jack Ashby	Research Director	MedPAC

Appendix 4 – ARS Write up and Notes from Moody’s Investors Services on ARS and VRDOs

Disruption in the Auction Rate Securities Market⁷

Auction rate securities (ARS), which were first introduced in 1984, are securities whose interest or dividend rate is reset periodically. ARS typically have a long term nominal maturity that can extend to 25 and 30 years (or in the case of preferred stock issued by closed-end funds, no maturity). Interest rates are reset through a Dutch Auction process at predetermined short-term intervals, usually 7, 28 or 35 days. Although ARS are issued and rated as long term bonds, they are priced and traded as short-term instruments because of the interest rate reset mechanism and the willingness, historically, on the part of broker dealers to provide clearing bids so as to maintain an orderly market, ensure the success of each auction, and provide liquidity to investors who may have wished to sell.

The success of the auction rate market, which now stands at about \$328 billion (including public finance and other sectors), can largely be attributed to the fact that investors were attracted by the incremental yields offered by these instruments, which had come to be viewed as money market alternatives in terms of liquidity. Issuers, on the other hand, benefited from the lower cost of financing long-term obligations. Public finance issuers have issued increased amounts of auction bonds (as well as other forms of variable rate debt) since 2001 in order to lower borrowing costs by taking advantage of low short-term interest rates. The public finance auction bonds are primarily tax-exempt but also include taxable issues, and account for around \$165.5 billion or 50% of ARS outstanding. The issuers include both state and municipal governments and also non-profit hospitals, colleges and universities, housing finance agencies, and public utilities’ systems.

For a variety of reasons, municipal issuers have seen interest rates on auction bonds increase considerably since December 2007. The tightening of credit markets has increased investor sensitivity to the absence of a legal right to tender bonds (in contrast to variable rate demand obligations (VRDOs), the other common form of municipal variable rate debt, where the bondholders have tender rights usually supported by external liquidity facilities). Whereas before these events, auction bonds were generally expected to trade at a fairly narrow spread above the benchmark (the SIFMA swap index for tax-exempt bonds, and one or three-month LIBOR for taxable bonds), spreads widened to as much as 100-200 basis points (or in some cases more), with the last two weeks bringing additional significant increases. Reduced demand for the auction product has led to an increasing number of failed auctions, as the number of sell orders began to greatly exceed the number of buy orders. These failures increased as broker-dealers were no longer able to provide bids to cover the difference (as discussed in more detail below). The auction is deemed to “fail” when there are not enough buy-side orders (including bids by

⁷ Much of the following discussion is excerpted from two special reports published by Moody’s Investor Services. The full reports are provided in Appendix 4 to this document.

broker-dealers, if any) to cover the submitted sell orders by existing holders. When an auction fails, the interest rate is determined by the legal documents for the issue. In some cases, the rate is set by a formula (for example a percentage of LIBOR), which may remain relatively low in absolute terms while market interest rates remain low; for other issues, the rate may jump to a maximum rate, which may be 15% or more.

The recent financial stress experienced by monoline bond insurers may also contribute to reduced investor demand. A significant percentage of municipal auction bonds has been covered by bond insurance policies issued by the monoline insurers. Beginning in December, the ratings on certain bond insurers began to be placed on watch for possible downgrade (or in two cases downgraded) due primarily to their exposure in areas other than municipal finance. These developments have caused some investors to reduce their exposure to these monolines. Although these holders have no right to tender their insured auction bonds, they would become sellers rather than buyers, thus further depressing demand in the sector.

Interest Rate Hedges Do Not Offset Current Cost Increases

In many cases, issuers have combined variable rate debt (including auction bonds and variable rate demand bonds) with floating-to-fixed rate interest rate swaps. These transactions have allowed issuers to effectively “lock-in” the lower interest rates associated with variable rate debt, for longer periods of time. The interest rate paid by the issuer remains at this lower short term level as long as swap payments are in line with the spreads required in the auction market.

For example, an issuer might have entered into a swap under which it makes periodic payments to the counterparty at a fixed rate (for example, 4%) and receives periodic payments from the counterparty at a variable rate based on a benchmark (for example, 67% of one-month LIBOR). These issuers often did not budget for higher interest rate costs because of the expectation that the swap would hedge the interest rate risk. Specifically, they assumed that variable rate payments received on the swap (67% of LIBOR) would usually offset the variable rates paid on the auction bonds (the SIFMA swap index, plus a modest spread). At times when the variable payments did offset each other, the issuer’s effective interest expense would be the fixed swap rate (4%), subject to relatively modest basis spreads between variable payments. Other issuers did not add hedges, and thus are subject to the risk of rising interest rates (not a near-term concern in today’s low interest-rate environment).

In the current environment, however, the variable swap payments may fall well short of offsetting the high spreads required in the auction market. In recent months, auction bonds have traded at a wide spread relative to SIFMA. In the example, the issuer would receive approximately 2.07% from the swap counterparty (67% of one-month LIBOR, which is currently about 3.09%). If the auction bonds reset at 8%, the issuer would pay the difference (5.93%), in addition to the fixed swap rate of 4%. Indeed, in this example, the issuer’s total expense (9.93%) would be higher than if there had been no hedge (8%). While the interest rate hedges serve a valuable purpose in protecting against high interest rate environments and in hedging costs when spreads are within predicted ranges, they do not always offset unanticipated jumps in interest rate spreads.

Principal Credit Issue is Ability to Sustain Higher Interest Costs, Not Liquidity

Because the bondholders have no right to tender the bonds, the primary effect of auction market conditions on municipal issuers is increased interest expense due to the higher interest rate resets. This may lead to interest costs exceeding budgeted amounts. Many issuers can manage the higher interest rates they may have to pay on their auction rate securities because interest expense is not a high percentage of their operating costs. However, there may be some issuers with narrower operating margins who will experience rising budgetary stress if the high rates persist for the medium or long term. Factors that will determine the level of stress include: 1) the amount of basis point increase in the interest rate levels being experienced and their effect on the issuer's net revenues and debt service coverage; 2) whether the increased rate on a failed auction is moderated by a formula linked to an index or jumps to a high maximum rate possibly ranging upwards of 15%; 3) the issuer's ability to cut expenses or raise revenues to pay higher debt service; 4) the likelihood that the spreads will re-stabilize at manageable levels; and 5) the issuer's ability to restructure the auction bonds, either by exercising a right to change the interest rate mode of the bonds or by refunding the bonds with a new issue.

A significant number of municipal issuers are seeking to restructure the debt so that it is no longer in an auction mode. The bonds are generally redeemable at par by the issuer, allowing the issuer to either call for their tender or redemption. The issuer's options include remarketing the bonds in another variable rate form (most commonly as VRDOs) or as fixed rate bonds. If remarketing is not feasible, the issuer can redeem the bonds and refund them with new debt, again either in a different variable rate mode or as fixed rate debt.

Conclusion Regarding the ARS Market

The ARS market has been underpinned by an assumption that asset liquidity would always be available. Except in connection with a limited number of credit linked events in the comparatively low volatility markets prior to 2007 broker-dealers had been ready, willing, and able to support auctions and provide liquidity to investors. Conditions since the middle of 2007, however, have changed dramatically. The auction rate market has now been severely disrupted, thus impacting various auction rate securities, including tax-exempt and taxable municipal securities. Absent a willingness on the part of broker-dealers to offer liquidity under current market conditions, we would expect additional auction failures in the future (although there have been some indications that new buyers may provide some measure of stability at higher yields). This outcome is possible, notwithstanding the fact that the underlying credit quality of many issuers remains strong in the short-term even as interest expenses spike up. Should conditions in the auction rate market not improve, however, this development could have negative implications for long-term ratings on some public finance issues, if increased interest expense materially impacts debt service coverage levels. Wherever possible, analysts also expect various issuers to explore alternatives to the ARS market, such as the restructuring of the auction bonds, either by exercising a right to change the interest rate mode of the bonds or by refunding the

bonds with a new issue, or securing other forms of financing, such as bank credit facilities. Recent reports indicate that some additional buyers for auction rate bonds have emerged, attracted by the relatively high yields produced by auction resets. Over time, it is possible that the market may stabilize at a reduced volume, making it more feasible for issuers who chose not to restructure to continue in auction mode provided that the stabilized interest rate spreads are sustainable.

The short term impacts of this disruption will likely be a return to interest rate levels more in line with historical long term interest rates (from the more favorable levels experienced in the 2003-2007 period) and some additional financing costs sustained by borrowers as they seek to refinance existing offerings and attempt to secure alternative credit enhancements (Letters of Credit).

Appendix 5 – Summary of Discussions and Interviews with Financial Experts

Bond Rating Agency Perspective - Jeff Schaub, Fitch Ratings

The meeting of the Financial Conditions Work Group began in December 2007 with a presentation by Mr. Jeff Schaub about the current credit environment for acute care hospitals, factors that affect credit evaluations, and credit factors specific to Maryland's acute care hospitals. Mr. Schaub stated that overall, credit was available to hospitals at good terms, noting that recent activity in the sub-prime housing market had not had much direct effect on the availability of credit for hospitals. Mr. Schaub foresees a continuation of the 2007 healthcare credit environment through 2008, although he expects bad debts to grow due to rising deductibles and increasing numbers of uninsured healthcare recipients. He also expects lower, although still normal, investment returns. Two continuing themes from 2007 that Mr. Schaub chose to highlight were increasing physician/hospital alignment and lower interest rates, the latter of which will continue to encourage extensive borrowing. Looking to 2009, Mr. Schaub stated that health care reform, economic recession, and fiscal shortfalls at the state level may begin to have a negative impact on the credit environment for hospitals.

Mr. Michael Curran inquired as to whether malpractice or tort reform may have an impact on the credit environment. Mr. Schaub stated that malpractice expenses declined by about 2-3% due to demonstrated improvements in quality of care and safety. Mr. Ron Werthman inquired as to whether national trends regarding the supply of nurses and allied health professionals might have an effect on the credit environment. Mr. Schaub replied that hospitals have adapted to the nursing shortage by investing in information technology to better track and adjust staffing levels. He added that in Maryland, the strong relationship between hospitals and colleges have minimized agency expense.

Mr. Schaub continued his presentation by discussing the factors that are used to determine hospital credit ratings. These rating factors were organized into six distinct groups: management, market, medical staff, strategy, capital needs, and financial performance. Mr. Schaub noted that a few of the factors (succession planning, demographics, and physician/hospital alignment) were becoming increasingly important. He also noted that, amongst the financial performance factors, liquidity, debt load, and profitability explained most of the variance between hospitals.

The final part of Mr Schaub's presentation included a discussion of credit considerations specific to Maryland. Mr. Schaub identified the positive considerations as demographics (i.e., affluence and growth), economic stability, strong clinical affiliations, investment level, and rate predictability (i.e., stability). Negative considerations included an overly competitive markets in some areas, price constraints, regulatory review requirements, and patchwork subsidization of uncompensated care as manifested in one-time rate adjustments. Mr. Robert Murray stated that he would be able to explain some of the intricacies of the reimbursement system to Mr. Schaub at a later date.

Mr. Schaub compared Maryland acute care hospitals to national hospitals on a variety of

financial measures. He noted that although the median for Maryland hospitals on these measures was often lower than the national median, Maryland hospitals were given more favorable ratings due to the stabilizing effect of the rate setting methodology and other intangible aspects of Maryland's healthcare system.

Mr. Chuck Orlando inquired as to whether Maryland's bond indemnification program was a significant credit factor. Mr. Schaub replied that he would need to think about it some more, but his initial reaction was that it would not have a significant impact. Mr. Orlando also inquired as to Mr. Schaub's opinion about the HSCRC's recent decision to change the reimbursement rate for 2008. Mr. Schaub responded that the action was not significant enough for Fitch Ratings to contemplate any kind of rating adjustment.

Bond Rating Agency Perspective – Beth Wexler, Moody's Investors Service

Ms. Beth Wexler began her presentation with an environmental scan of the healthcare industry. She stressed that Medicare reimbursement is likely to slow and that changes in payment structure and payer concentration are likely to drive down commercial reimbursement. She added that investment portfolios and debts structures within the industry were becoming riskier, that physician shortages were becoming more acute, and that the healthcare industry was likely to face increasing scrutiny from both public and private "watchdogs." To these remarks, Mr. Dan Steingart added that the upcoming election will be influential in determining the degree to which Medicare reimbursement slows, that rising bad debt was outstripping inflation, and that nursing shortages were likely to intensify with the physician shortages, although both would apply to predominantly rural markets.

Mr. Murray stated that it was likely that Medicaid in Maryland would be expanded to cover an additional 100,000 individuals, and that there will be a one-time reduction in uncompensated care. He noted that this reduction would be revenue neutral with regard to the hospitals. Ms. Wexler replied that this was likely to be a positive credit factor.

Mr. Curran inquired as to whether malpractice or tort reform were having a positive effect nationally. Ms. Wexler replied that she thought tort reform was mostly stabilizing otherwise unstable markets, although she had heard, anecdotally, that it was having a positive effect in Texas.

Ms. Wexler discussed important credit factors for Moody's. She stated that Moody's looks primarily for proactive management with a mix of new and tenured members that are able to articulate and implement linked capital and strategic plans. She explained Moody's rating system, noting that the rate setting methodology in Maryland has produced an artificial floor below which few hospitals fall. Accordingly, there is only one speculative grade hospital in Maryland, while the median rating for Maryland hospitals was the same as the national median, i.e. A3. She explained that, across a variety of financial measures, Maryland hospitals were trending favorably, although performance appeared to be slowing. Maryland hospitals have, historically, lagged behind the national medians but seem to be closing the gap.

Ms. Wexler discussed Moody's view of the Maryland rate system, noting that it remains an advantage by providing greater predictability of financial performance, supporting weaker providers, and compensating for the modest liquidity of many Maryland hospital portfolios. She added that the proactive management of environmental influences (nursing shortages, pay-for-performance methodology) and the HSCRC's resources are a positive credit factors for Maryland hospitals. She concluded by noting that the HSCRC's mid-year adjustment of reimbursement rates created some uncertainty and anxiety amongst providers and in the capital market. She stressed that it was the uncertainty, rather than the magnitude of the rate cut, that caused the anxiety.

Ms. Wexler also highlighted some of the other positive credit factors for Maryland hospitals including favorable demographics, low competition in certain areas, and cash flow predictability. She noted that some of the negative credit factors included thin balance sheet resources, a heavily consolidated payer environment, dysfunction between rate-regulated and unregulated providers, confusion about the regulatory environment, and recent rate activity.

Mr. Paul Sokolowski inquired as to whether physician shortages were unique to Maryland. Ms. Wexler replied that there were physician shortages nationwide and described a few of the initiatives taken to ameliorate the effects. Mr. Sokolowski also inquired as to shortages in allied professions. Ms. Wexler replied that there were shortages in many of the allied professions.

Bond Insurer Perspective – Steve Renn, Ambac Assurance:

Mr. Steve Renn began by noting his previous experiences working within the Maryland healthcare environment. He reported that the capital market view this environment as being very stable. He mentioned that the all payor rate setting system is the most distinguishing feature of Maryland's healthcare environment and is viewed by many as one of the best functioning all payer rate setting systems in the country. He credited this system with strong use of data and information. He added that it was his impression that the HSCRC enjoyed the broad support of the hospital industry, payor community, physicians, business community, as well as the legislature. Mr. Robert Murray amended this statement by noting that support for the HSCRC waxes and wanes, although it does regularly enjoy strong legislative support. Mr. Ron Werthman concurred with Mr. Murray's assessment.

Mr. Renn stated that some of the concerns Ambac had regarding the Maryland hospital system included what would happen if the HSCRC lost its Medicare waiver or if the Commission was dismantled entirely. He added that, as bond insurers, they were concerned about lower levels of cash liquidity and tighter balance sheets for Maryland hospitals. He noted that the lower levels of cash liquidity were probably due to lower retained earnings over the years resulting from the HSCRC's goal of reducing case-adjusted costs and charges. Mr. Murray commented that from 2004-2007, the HSCRC did scale back its cost containment drive and permit hospitals to retain a greater percentage of their earnings so that they might recapitalize. Mr. Paul Sokolowski stated that there is support for the current rate setting system, although the hospitals do feel as if

the Commission is too tight sometimes. Mr. Sokolowski inquired as to where Ambac felt Maryland hospitals placed with the nation with regards to financial condition. Mr. Renn stated that, along with Mr. Jim Mullins, he has stressed how the rate setting system offsets lean balance sheets, placing them in a better financial condition than might be expected. Mr. Renn also expressed his concern that the financial information he had available (circa 1999) did not represent a current profile of the financial condition of the Maryland hospital system. Mr. Murray stated that the financial situation has changed significantly since then and added that hospital groups were currently running total margins in excess of 5%. He noted that he would be happy to provide Mr. Renn with more current information.

Mr. Ron Werthman inquired of Mr. Bruce Gordon as to whether the slim balance sheets of Maryland hospitals were offset by the state's rate setting system. Mr. Gordon responded that it was his perspective that the rate setting system had a moderating effect on the market, producing fewer high performance hospitals as well as fewer low performance hospitals. He added that in a freer market environment some hospitals might rise to a AA rating, but some hospitals would certainly fall in terms of ratings.

Mr. Hal Cohen noted that hospital charges are lower in Maryland than elsewhere because everyone pays. Mr. Cohen also observed that if the HSCRC was to be dismantled, then Maryland hospitals would certainly be able to collect more from private insurers. He questioned, however, whether this would make up for the loss in Medicare and Medicaid payments. Mr. Renn thanked Mr. Cohen for his comments and noted that Ambac's perspective on the Maryland healthcare environment was slightly out-of-date. Mr. Renn continued by expressing his opinion that Maryland's rate setting system may have inhibited the formation of multi-hospital systems by shielding them from competitive market forces. He added that Maryland seemed to have fewer large clinics than other areas of the nation, although it was unclear whether this was related to the rate setting system.

Mr. Murray commented that Maryland hospitals have moved away from a total patient revenue system as total case loads have risen. He noted that the latter event has been beneficial to hospitals from a balance sheet perspective but has hurt the state by raising total costs. Mr. Murray inquired as to Mr. Renn's perspective on how the recent credit market activity may affect the availability of credit for Maryland hospitals. Mr. Renn stated that he would discuss that at the end of his presentation.

Mr. Renn continued his presentation by noting that it was Ambac's philosophy to place financial ratios at the end of the analysis. He commented that Ambac was concerned about the possibility of deferred capital spending amongst Maryland hospitals, although he added that they were impressed by the quality of senior management.

Mr. Renn concluded by stating that it was Ambac's overarching goal to regain AAA status with the primary bond rating agencies and to restore investor confidence in the trading values. Mr. Murray once again noted his availability and desire to update Mr. Renn and Ambac Assurance on the current activities of the HSCRC and Maryland healthcare industry.

Commercial Bank Perspective – Don Kohlhafer, Bank of America:

Mr. Don Kohlhafer began his presentation by observing that the current credit market is volatile. Mr. Kohlhafer stressed that the most significant difference between a commercial bank perspective and that of a bond insurer is “the length of the bet.”

He continued by discussing comparisons between Maryland’s acute care marketplace and the nation’s. He noted that some of his comparisons were slightly suspect because of split risk ratings. Mr. Cohen inquired as to the number of entities within each of the medians. Mr. Kohlhafer responded that the Maryland medians included 12 obligated groups with A ratings and 9 obligated groups with BBB ratings. Mr. Robb Cohen noted that Moody’s medians probably encompassed about 230 entities of a universe of about 5,000. Mr. Murray commented that he thought Mr. Robb Cohen was trying to make the point that Maryland has a higher proportion of investment grade hospitals than most states. Mr. Murray also observed that within any given rating, Maryland hospitals tended to be more leveraged. Mr. Kohlhafer noted that the level of dialogue between the HSCRC and its constituency was very high and added that this made Maryland somewhat unique. It was his belief that this dialogue mitigated some of the negative side effects of the waiver last year.

Mr. Kohlhafer stated that balance sheet indicators, such as liquidity, were important for credit considerations because they indicate how well a hospital might be able to survive rough financial conditions.

Mr. Barry Rosen inquired as to what, in Mr. Kohlhafer’s opinion, were the most salient financial medians in evaluating the credit-worthiness of hospitals. He also inquired as to whether debt-to-EBITDA was an important measure of financial condition. Mr. Kohlhafer replied that debt service coverage is an important indicator of credit-worthiness. Mr. Jerry Schmith concurred with Mr. Kohlhafer’s reply. Mr. Murray stated that it would ultimately be necessary for the work group to develop a list of financial goals. Mr. Stuart Erdman commented that it was his experience that bond insurers, banks, and rating agencies all use the measures that Mr. Kohlhafer had included in his handout.

Mr. Paul Parker inquired as to whether Mr. Kohlhafer thought that Maryland hospitals were undercapitalized compared to other hospitals in the nation and whether there are better measures of undercapitalization besides age of plant. Mr. Kohlhafer noted that there are clear efforts to recapitalize hospitals and that debt-to-capitalization is an important index of capitalization. Mr. Schmith stressed the need to look beyond the hospital entity and the obligated group to other institutions associated with hospitals, which should improve the balance sheet outlook for most hospitals, especially as regards days of cash on hand. Mr. Erdman noted that the flip side of that is that there can be cash drains in those institutions which affect the hospital.

Mr. Murray questioned the goal of trying to raise Maryland hospitals to the level of Moody’s medians. Mr. Kohlhafer stated that he was not in a position to advise the work group on a specific target. Mr. Rosen suggested using stratified goals: one for the state as a whole and one

for the state's investment grade hospitals. Mr. Cohen commented that all of the medians presented by Mr. Kohlhafer were revenue driven and reminded the work group that it is a part of a cost review commission and should keep that fact in mind. Mr. Murray referred Mr. Cohen to the work group's purpose statement.

Investment Management Perspective – Lilly Scher, Eaton Vance:

Ms. Lilly Scher began her presentation by providing an overview of the healthcare credit environment from 2002 through January 2008. She noted that from 2002 – June 2007, municipal bond performance was very strong due to favorable economic conditions, strong issuer supply, and strong demand from traditional and non-traditional buyers. Demand was kept strong by an absence of negative credit events. She continued by stating that 2006 saw a growth in the number of non-traditional buyers of healthcare bonds, including arbitrage players and hedge funds. This created a relative shortage of municipal healthcare paper and led to spread tightening. In 2007, bond insurers backed off on the par amount they were willing to underwrite and more un-enhanced hospital issuance came to market. Hospital issuers used favorable conditions prevalent then to restructure debt at extremely attractive rates. From 2004 – 2007, hospital bond issuance grew substantially, with the greatest increases in un-enhanced issuance. Ms. Scher anticipates that the proportion of un-enhanced issuance will grow, as the number of AAA-, AA-, and A-rated insurers contracts due to insurer related enterprise fall-out. Depending on the broader market climate, the level of absolute issuance could moderate over the next few years, but she added that the capital intensiveness inherent in the healthcare sector should keep issuance relatively strong with the role of the traditional buyer reasserting its importance and providing the basis for more selective value oriented investment by the capital markets than has existed over the last several years.

Next, Ms. Scher discussed hospital bond pricing and performance. She stated that, in contrast to the immediate post BBA years, hospital bond rating agency downgrades had little effect on pricing as investor demand and the market's generally resilient tone kept price distinctions between credit ratings thin. This led to a situation where hospital bond pricing bore little relation to the actual credit risk. By December 2006, bond spread compression had reached a peak. In March 2007, healthcare spreads began to widen across all rating categories, however, spread widening was the fastest and greatest within the BBB rating category.

Ms. Scher anticipates that in the future the market will be much more "credit-driven." Specifically she stated that she expects that the importance of credit risk assessment will re-assert itself over the next few years, with the capital markets' placing greater focus on credit ratings, "rating resiliency", and on security and legal provisions governing the issuer's financing documents in its investment selection processes. She added that fundamental revenue and expense pressures in the sector combined with technical changes in demand are likely to further favor hospital spread widening and pricing distinctions according to rating band. Ms. Scher stated that credit is still widely available to hospitals, although the auction rate fall out and consequent rush to restructure may stress bank and insurer commitment availability. She concluded by saying that she expects that in the future, a more "credit-driven" environment will exact higher yields and wider spreads that are more commensurate with a hospital's credit risk

profile.

Ms. Scher moved on to discuss how Eaton Vance assesses the credit-worthiness of hospitals. She stressed that Eaton Vance follows changing industry and market dynamics and looks closely at whether providers are anticipating these changes. She advised that the work group read Moody's recent rating methodology publication. She noted that access to management and ongoing financial disclosure is a precondition for Eaton Vance to hold bonds. She reported that in assessing credit-worthiness, Eaton Vance places a premium on the location and uniqueness of a hospital's franchise model and, secondly, on the leadership's ability to respond to market and reimbursement changes by developing, articulating, and implementing a proactive business plan. She noted that increasingly, the analytic focus also takes into account an issuer's treasury management practices and asset/liability exposure-as, over the last five years hospitals have increasingly utilized less conventional tools to enhance investment earnings and balance sheet performance.

Ms Scher concluded her presentation with a few notes about Maryland. She stated that the rate setting methodology of Maryland protects Maryland hospitals from market volatility, although it also keeps earnings and consequently balance sheets thinner than national averages. She reported that Eaton Vance views the Commission's interventions positively. She ended by praising the Maryland healthcare system for its openness and transparency.

Mr. Robert Murray solicited reactions from the meeting participants. Mr. Robert Chrencik inquired as to whether bond insurance was still viable for lower rated hospitals. Ms. Scher replied that she did not think that uncertainty in the bond insurance market would hurt lower rated hospitals provided it is viable over the long term. Ms. Marcy Lash concurred with Ms. Scher that credit was available to lower ranked hospitals but at a higher premium.

Investment Management Perspective – Marcy Lash, T. Rowe Price Associates:

Ms. Lash began her presentation by explaining that T. Rowe Price invests heavily in hospitals due to their higher absolute yield and total returns and despite their volatility. She noted, however, that hospitals will find it difficult to replicate the strong financial performance of the past few years. She identified six factors that will drive down hospital performance over the next several years: 1) the moderation of Medicare reimbursement, 2) the growing importance of P4P reimbursement, 3) greater scrutiny of charity care policies, 4) growing budgetary concerns including employee benefits, supplies, and bad debts, 5) growing capital expenditures, particularly related to electronic medical records systems, and 6) inconsistent patient volume trends due to self-rationing of healthcare and competition with physicians for patients. She added that although the industry as a whole will see leaner operating profits, the industry will remain relatively stable due to high levels of liquidity.

Ms. Lash highlighted some of the important qualitative factors that T. Rowe Price uses to evaluate the credit-worthiness of hospitals. She stressed the importance of location in particular due to the fact that hospitals draw their clients from very distinct geographic areas. She noted that the presence of other competitors, staffing issues, the stability and historical success of

management, board involvement, and regulatory/reimbursement issues were also important.

Ms. Lash continued by highlighting some key financial ratios that she uses to evaluate hospitals. She stressed the importance of stable operating margins, days' cash on hand, debt-to-capitalization, debt-to-cash flow, coverage of maximum annual debt service, and capital expense-to-annual depreciation.

Ms. Lash indicated some of the important legal provisions that T. Rowe Price looks at in evaluating hospital bonds. These provisions were a mandatory gross revenue pledge, a mortgage for lower rated hospitals, language for permitted liens, rate covenants, and additional debt provisions.

Ms. Lash summarized the financial condition of Maryland hospitals, stating that they tend to exhibit greater stability than hospitals nationwide, but within a narrower credit band at lower average ratings. She noted that the rate setting system in Maryland has been a positive stabilizing influence. Mr. Hal Cohen inquired as to how many non-Maryland hospitals T. Rowe Price had in their portfolio. Ms. Lash reported that T. Rowe Price had 136 non-Maryland hospitals. Mr. Cohen stated that their sample of national hospitals may not be representative, making comparisons difficult. Ms. Lash replied that their sample was probably representative due to their investment strategy. Mr. Robb Cohen replied that rated hospitals were a self-selecting group to begin with. Ms. Lash further replied that the ratings in her chart reflected T. Rowe Price's ratings and not those of the rating agencies. Mr. Robb Cohen inquired as to whether Ms. Lash saw the potential implosion of the bond insurance market as an opportunity to purchase underrated hospital bonds. Ms. Lash replied affirmatively. Mr. Hal Cohen inquired as to what Ms. Lash thought of the Maryland bond indemnity program. Ms. Lash stated that it was not factored into credit ratings but did influence bond purchasing decisions.

Measuring Hospital Productivity Improvement – Jack Ashby, MedPAC:

Mr. Robert Murray introduced Mr. Jack Ashby, noting that he was an observer, advocate, and friend of the Maryland healthcare system. Mr. Murray then requested Mr. Ashby's perspective on the issues associated with measuring hospital productivity improvement. Mr. Ashby began by describing MedPAC's position on measuring productivity improvement and noted that MedPAC believes that hospitals should be expected to improve productivity by a modest amount each year with no cost to quality. He also noted that, as market competition demands constant productivity improvement in the private sector, Medicare should demand the same.

Mr. Ashby continued by stating that MedPAC's efforts to measure productivity improvement began over 15 years ago. He explained that any measure of productivity needs to include inputs and outputs with quality held constant. MedPAC's first efforts at measuring productivity were directed towards labor productivity and examined occupation-mix adjusted labor hours relative to real case-mix adjusted and outpatient adjusted admissions. Mr. Ashby noted that it was important to parse out case-mix increases due to improvements in coding from real changes in case mix. Using this measure, MedPAC determined that there were real productivity increases

during the first two, and only the first two, years of PPS.

Next, Mr. Ashby described the second phase of MedPAC's efforts to measure productivity improvement. During the 1990's, MedPAC observed that limiting inputs to labor inputs left out important information about capital costs, since many improvements in productivity are due to substituting capital for labor. MedPAC then began to measure productivity improvement as a function of cost per case deflated by market basket (operating and capital). MedPac also developed an alternative, and more controversial, measure of productivity, by taking aggregate productivity (cost-deflated, real case-mix adjusted admissions) as a function of productivity for individual services and intensity of services per admission. Using this measure, MedPAC determined that during the late 1980's and early 1990's, hospitals were improving productivity in services, but these improvements were canceled out increases in the intensity of services. Later in the 1990's, service intensity decreased, while productivity for individual services remained constant. Mr. Ashby noted that at the end of the decade, MedPAC lost the ability to measure the intensity of services because the CPI measure (hospitals and related institutions) was altered in ways that made it better for measuring inflation for hospital services but unfit to calculate service intensity.

Mr. Ashby commented that productivity increase measurement is problematic today, because it is difficult to forecast market basket changes. Additionally, it has become more difficult to parse out real vs. recoded case-mix increases. Mr. Ashby concluded by stating that it is still MedPAC's conviction that hospitals should be able to increase productivity if productivity is increasing in the rest of the economy. He noted, however, that whether service industries can increase productivity at the same rate as manufacturing is still a topic of some debate.

Mr. Murray inquired as to the value of measuring productivity improvement at either the national or state level. Mr. Ashby replied that it might be helpful to monitor productivity in a P4P setting.

Mr. Ray Grahe requested that Mr. Ashby elaborate on his earlier comment regarding the relative rates of increasing productivity in manufacturing and service industries. Mr. Ashby explained that service industries have higher ratio of labor to capital inputs that cannot always be reduced. To illustrate this point further, Mr. Ashby noted that an hour of babysitting always takes an hour.

Mr. Bob Vovak inquired as to how quality was measured. Mr. Ashby stated that how quality is measured is still an unresolved issue. Mr. Ashby added that historically, MedPAC has often assumed that quality remained constant. He noted that more recently, there are a few measures of quality, but it is unclear how they should be weighted.

Dr. Cohen inquired as to whether there were productivity improvements that were associated with increased volumes. Mr. Ashby replied that for the last four to five years inpatient cost per case was growing faster relative to outpatient cost per case, and at least one of the factors in that pattern appeared to be larger volume growth on the outpatient side. Dr. Cohen commented that this did not seem to be happening in Maryland.

Mr. Murray inquired as to whether there will be more of an emphasis on productivity as

Medicare faces increased threats to its budget and trust fund. Mr. Ashby replied that he believes that this will be the case. Mr. Paul Parker inquired as to whether there was a relationship between competition and productivity, in particular with regard to discrepancies between inpatient and outpatient care. Mr. Ashby replied that MedPAC had not looked into this relationship very much, but noted that in certain markets with greater financial pressures, there seems to be greater productivity. He added that it does seem as if relative increases in productivity in outpatient care versus inpatient care are related to greater competition from market entrants into outpatient care.

Mr. Vovak inquired as to why Medicare cost per-case increases have been greater in recent years. Mr. Ashby replied that this was due in part to emphasis on quality improvements and improving nursing staff ratios. Additionally, under managed care in the 1990's, private payers put a lot of pressure on hospitals and this coincided with a low rate of cost growth. Pressure from private payers has waned since 2000, and this has coincided with the much higher cost growth.

Appendix 6 – Maryland Performance on the Financial Conditions Indicators 1993-2006

**Appendix 7 – Operating Performance FY 2008 vs. FY 2007 (HSCRC
F/S “unaudited” financial statements)**