The Health of New Hampshire's Community Hospital System

A Financial and Economic Analysis

Section I – New Hampshire's Community Hospitals and the Health Care Market




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New Hampshire's Community Hospitals and the Health Care Market

New Hampshire's citizens depend upon a strong and responsive community hospital system to assist in meeting the health care needs of their communities. While the role of hospitals continues to evolve with the rapidly changing health care system, the benefits these institutions bring to their communities are no less diminished. New Hampshire's hospitals are an important part of the State's safety net system for the poor, the uninsured and other vulnerable populations. Insurance coverage alone does not equal access to care; availability of providers makes it a reality. One of the most visible - and appreciated - roles citizens attribute to hospitals is the provision of emergency medical services. Therefore, the State has a compelling interest to ensure that its citizens can avail themselves of appropriate and timely hospital services.

Many different payers in the health care system rely on hospitals to be financially sound and able to provide the mix of services needed by their clients. State government purchases services for the Medicaid population, State employees, their families and retirees. Health plans and insurers need these institutions in their networks in order to provide adequate coverage to businesses and their employees. The federal government has similar interests for the large and growing number of Medicare beneficiaries. All depend on a statewide presence of providers that can meet the needs of their populations in both urban and rural parts of the State.

Community hospitals are also a source of civic pride. They provide jobs, attract businesses and health professionals, and often serve as a rallying point for communities to come together around health care needs. Hospitals furnish many volunteer opportunities, chief among them the long-standing tradition of community service on a hospital board of directors.

During the 1990s, the Legislature became involved in activities to expand access to care for New Hampshire's poor, uninsured and vulnerable populations that reduced some of the financial burden the uninsured imposed on hospitals. One of the earliest actions was the expansion of the Medicaid program for pregnant women and children. [1] The "primary care initiative" of the mid-1990s led to the development of Community Health Centers (CHCs) to deliver primary and preventive care to the poor and uninsured, thereby decreasing some of the costs to hospital emergency rooms. [2] This initiative also resulted in the establishment of the Primary Care Recruitment and Retention Center and the increased designation of Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs), both of which helped attract health professionals to underserved areas.

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[1] Medicaid coverage was expanded to all children 0-18 years of age up to 185% of the Federal Poverty Level (FPL). Pregnant women were covered up to 185% of the FPL. The Children's Health Insurance Program (CHIP) expanded insurance coverage to those previously ineligible for Medicaid (children in families who earn up to 350% of the FPL) and allows infants up to the age of one to receive Medicaid benefits (in families that earn up to 300% FPL).

[2] See *Strengthening the Safety Net: A Financial Analysis of New Hampshire's Community Health Centers*, released by the NH DHHS October, 2000. A copy can be obtained on the Department's website: **www.dhhs.state.nh.us**

Several more recent initiatives have had, or have the potential, to effect the financial position of hospitals. Through the Community Grant Program, the Department of Health and Human Services has partnered with New Hampshire's community hospitals to assist them in developing innovative programs and services that met identified community needs. [3] SB 183 created the Adult Coverage Subcommittee of the Healthy Kids Corporation to explore options for expanding health insurance coverage to adults. The most recent initiative - Critical Access Hospitals - is a federal government program aimed at mitigating the financial effects of the Balanced Budget Act of 1997 on small rural hospitals. [4]

In the past several years, there has been increasing interest around the country in holding nonprofit organizations accountable for the charitable assets they control. The magnitude of the charitable assets that reside in nonprofit hospitals has focused attention on them. The New Hampshire Legislature has indicated its interest in the role of the community in the decision making process of the State's nonprofit health care institutions. In 1997, it codified the role of the Attorney General's Office in dealing with for-profit acquisitions of health care charitable trusts and the transfer of assets between nonprofit health care charitable trusts. This was followed by the 1999 enactment of the community benefits statute that calls for public accountability on how health care charitable trusts meet their missions. [5]

Hospitals have changed as the health market changed. A hospital is no longer a building with four walls. Many, if not most, of the hospitals in this and other states are part of systems, alliances, integrated networks or affiliations. Oftentimes this means that a hospital is one of several entities that come under a holding company that controls other entities, such as a nursing home, physician practice, skilled nursing facility, home health agency and/or rehabilitation facility. These related entities could be nonprofit or for-profit. The effects of these new configurations and the increasing concentration in the provider market are still unclear.

Consolidations and mergers and financial difficulties have characterized the New Hampshire health insurance market in recent years. Two large, national for-profit firms now dominate that market. Whatever bargaining power the insurers might have in the hospital market and its subsequent effects on affordability and access, presents another uncertain outcome.

While many hospitals in New Hampshire and around the country were posting healthy financial results, Congress decided to reign in Medicare spending to balance the federal budget and prevent the (Medicare Part A) Hospital Trust Fund from running out of money. Much has been written about the negative impact on hospitals' bottom line and whether or not Congress went too far. Some relief has been granted (the Balanced Budget Refinement Act of 1999); more could be coming judging by the myriad of bills winding their way through Congress. What is clear is that

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[3] Examples include the pharmacy program at Cheshire Hospital, the workman's compensation project at Exeter Hospital, dental programs at Concord and Lakes Region Hospitals, and school-based primary care at Upper Connecticut Valley Hospital.

[4] States with small rural hospitals may designate those hospitals as Critical Access Hospitals (CAH) under the federal (Medicare) Rural Hospital Flexibility Program. The advantage to the hospital is that Medicare reimbursement to the CAH is based on the facility's "reasonable costs" to deliver care; frequently, this is a better payment than the current system. A CAH may have no more than 15 acute care beds and 10 "swing beds" (for a total of 25 beds). In addition, the yearly average length of stay can be no more than 96 hours.

[5] New Hampshire's community benefit statute applies to all health care charitable trusts (such as hospitals, nursing homes, home health agencies, Community Health Centers). At the time of its passage, NH was the only state whose statute had such a broad scope. Massachusetts has voluntary guidelines that apply to health plans as well as hospitals.

hospitals are being forced to adapt to one of their biggest challenges since the introduction of the inpatient Prospective Payment System (PPS) in 1984.

The Changing Roles of Hospitals

The Historical Evolution

The original hospitals in this country were chiefly for the poor and were viewed as places of disease and death. Around the turn of the last century, hospital services were paid for by donations of the local philanthropists and governments; hence, the term "charitable" institutions came to be used. A number of things occurred to change the notion and function of a hospital, one of these being payment for hospital services (Gray, 1991), followed by widespread health insurance coverage and its tie to employment (Starr, 1984) after World War II.

The number of hospitals and hospital beds increased after World War II with the establishment of two federal construction programs – one to expand the Veterans Administration hospitals, the other (the Hill-Burton program) to expand community hospitals. Federal government/public involvement grew further with the inception of the Medicare and Medicaid programs in the mid-1960s. When these two programs were passed, many believed that the problems of the poor and uninsured were solved. Medicare also grew to encompass more than medical care for seniors; it also subsidized certain "social goods" such as education of physicians and access for the poor.

Community Hospitals Today

One hundred years ago, hospitals refocused as the environment changed around them and health care services were brought inside the hospital walls (e.g., surgery). At the beginning of the 21st century, the concept of *what a hospital is* has continued to evolve in an increasingly complex industry. Many nonprofit health care entities organized as 501(c)(3) corporations are not independent companies, but rather a subsidiary of another health care entity or jointly owned or controlled by one or more entities (Prince, 1998).

The public and private sectors have utilized managed care and prepayment to decrease hospital use, which in turn has increased use of other providers. The federal government, alarmed by the outlays of the Medicare program, led the move to decrease hospital costs with the introduction of the inpatient Prospective Payment System (PPS) in 1984 (most often referred to as DRGs or Diagnosis Related Groups). Many believe that the outpatient prospective payment system (or APC - Ambulatory Payment Classifications) implemented by Medicare in the late summer of 2000 will be followed by private insurers, who still reimburse outpatient services on a fee-for-service basis (hence, outpatient procedures have been a source of revenue growth for many hospitals) (Modern Healthcare, January 2000).

Despite predictions to the contrary, few hospitals have closed their doors (the last hospital closure in NH was Newport Hospital in 1990), although there has been a steady decline in the number of occupied beds (Institute for the Future, 2000), with the national occupancy rate averaging 62% in 1997 (in 1998, NH hospitals had an average occupancy rate of 48%). Community hospital closures are fraught with political, social and economic implications.

While hospitals may not be closing their doors, industry representatives and financial analysts point to the "bifurcation" of hospital financial performance (Council on the Economic Impact of Health System Change, September 2000), or the separation of the industry into the "haves" and the "have nots" (Modern Healthcare, February 2000). The Institute for the Future reports that:

> *The overall financial success of American hospitals is uneven - one-third of hospitals are failing, one-third are just getting by, and one-third are doing extremely well, particularly those that enjoy a geographic monopoly.*

Financial Pressures Changing Hospitals' Role

In the past several years, providers have scrambled to position themselves in the marketplace, whether through mergers or purchasing other providers. Sometimes these were defensive moves to hold onto a tenuous market position; other times they were attempts to increase market share. The results of these decisions have been mixed.

There are many different reasons for the financial pressures facing hospitals today. Some are due to legislative or regulatory actions, others due to business decisions like those discussed above, and still others simply due to the market area in which a hospital is located. A list of the most common reasons for financial difficulty includes:

- the Medicare reimbursement reductions of the Balanced Budget Act (BBA) of 1997;
- losses on managed care contracts;
- losses on physician practices and transfers to affiliates;
- new building and expansion projects;
- empty beds and an oversupply of hospitals;
- labor and technology costs; and
- the costs associated with complying with the Health Insurance Portability and Accountability Act (HIPAA).

The Financial Condition of Hospitals in 2000

For the most part, the news early in 2000 was not good for hospitals. Reports were released on the decrease of total margins (Modern Healthcare, March and December 1999) and the worst financial performance for the industry since the inception of the Medicare inpatient Prospective Payment System (PPS) in 1984. Moody's Investors Service predicted poor credit outlook in the nonprofit hospital sector for the next one to two years, primarily due to failed merger strategies and losses on investments in insurance products and physician practices (Moody's, January and April 2000). At the same time, health care analysts were predicting that hospitals would be focusing on revenue growth as they geared up for the effects of the Balanced Budget Act (Modern Healthcare, January and February 2000).

As the year progressed, reports of a "turn-around" - at least for some hospitals - began to appear in health care publications (Modern Healthcare, March and May 2000). HCIA-Sachs/Ernst & Young estimated that Medicare margins would break even in FY 2001 and reach a positive .05% in FY 2002. Still other reports cited growing evidence that hospitals were negotiating higher

rates from health plans and other non-governmental payers (Modern Healthcare, March 2000). [6] Standard & Poor's (Modern Healthcare, October 2000) predicted a positive outlook for nonprofit hospitals. S&P expected better operating results in 2000 and 2001 based on evidence that operating margins were recovering.[7] [8] Meanwhile, wholesale prices for acute care hospital services rose at their highest monthly rate in five years (Modern Healthcare, November 2000).

A summary of the reports discussed above, shows that hospitals were taking a number of steps to improve their bottom line, such as:

- lobbying for Balanced Budget Act relief;
- becoming more efficient (e.g., streamlining operations);
- improving billing and collection procedures;
- increasing the number of profitable services, including the development of new revenue sources;
- negotiating increases with private payers;
- depending on investment income; and
- considering Critical Access Hospital designation.

The Future of Community Hospitals

While it is difficult to predict the future, health policy experts have constructed different scenarios of what might happen to hospital revenues, expenditures and margins in the near term (Thorpe, Council on the Economic Impact of Health System Change). [9] One way hospitals are improving their bottom line is to refocus on core hospital services (e.g., inpatient and outpatient care). A common response has been to divest themselves of physician practices that are losing money (Center for Studying Health System Change, 2000). [10]

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[6] It is still unclear how much, if any, of the double-digit health insurance premium increases are going to hospitals. At any rate, we cannot expect all hospitals to fare equally well; ability to negotiate higher rates will be determined by market position.

[7] S&P saw continued strong liquidity and debt leverage. Reasons cited for their positive outlook were: cost reductions due to eliminating or revamping of unprofitable HMO and physician operations; BBA relief; and negotiated revenue increases with insurers.

[8] Though data for 2000 were not complete, the NH Hospital Association reported in their *Trending Report Second Quarter 2000* that NH hospitals had shown a marked decline in total and operating margins from the same quarter in 1999. Total margins had decreased 51%. Operating margins declined 34%, with rural hospitals at a negative 0.56%.

[9] Kenneth Thorpe of Emory University presented two different scenarios for private health insurers' payment to cost ratio at the September 6, 2000 conference "The Future of the American Hospital (1): The Financial Outlook" sponsored by the Council on the Economic Impact of Health System Change. If there were no further BBA relief and continued decline in private margins, the median hospital margin in 2002 would be –0.09. Adding the funds in the proposed provider restoration (stalled in Congress), the median margin would increase to 0.80. Higher payments from private plans would increase the estimated margin to 3.90. Combining both the Medicare increase and higher private payment would result in a median margin of 4.20.

[10] The Medical Group Management Association reported that the median loss for hospital owned multi-specialty practices per full-time physician was $53,365 in 1999, down from $79,794 in 1998 and $90,480 in 1997 (Modern Healthcare, October 2000). MGMA attributed the improvement to successful

When most industry officials, policy analysts and legislators discuss the health care market, the theme is continual evolution and constant change. Yet, some see an industry marked by change occurring at "glacial speed" (Morrison, 2000) with little likelihood of a new organizational structure emerging to replace the community hospital. Rather, they see a "hospital-centered" system (inpatient, outpatient, diagnostic, ancillary and physician practices tied together), reimbursement strategies that continue to push care out of the inpatient setting, and a surplus of hospitals (Institute for the Future, 2000).

Will hospitals evolve into a place for only the very sick (i.e., an intensive care setting) as more care is delivered in the outpatient setting? That is the view of one health care policy analyst who believes that health care is finally undergoing the "industrialization" that occurred some time ago in other American industries (Kleinke, 1998), with consolidation and integration of providers as the necessary steps to getting there. With this comes alignment of the incentives that drive physicians and hospitals. When that point is reached, J.D. Kleinke predicts that the HMO as we know it today will be by-passed and direct contracting with providers will become the rule rather than the exception.

Reasonable people may disagree with some or all of J.D. Kleinke's theories. Markets in rural states such as New Hampshire may not evolve into the high, medium and low priced segments that he sees in other (more urban) markets. Hospitals have lost money on physician practices (although Kleinke attributes this to the lack of shared ownership arrangements). Whatever the outcome, it appears that hospitals will be at the center of health care delivery for some time to come.

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negotiations to include incentives in the contracts of employed physicians, replacement of retiring physicians with younger more productive ones, and the divestment of underperforming practices.

A Summary of the Findings on the Financial and Economic Analysis of New Hampshire's Community Hospital System

Sections II and III contain the reports on the financial and economic status of community and teaching hospitals in New Hampshire. What follows below is a summary of the findings in those two reports upon which the *Recommendations for Action* are based.

A Healthy Hospital Sector. The Kane Report standardized the 1993-1999 audited financial statements for all 24 non-profit hospitals in the State. While a few hospitals experienced financial difficulties, the majority of the institutions exhibited strong financial performances in terms of their profitability, liquidity and solvency.

- **Profitability.** Between 1993 and 1999, median total margins and operating margins for New Hampshire hospitals exceeded those of the New England and U.S. hospitals for all but one year. The revenue and margins generated by different payers, however, varied significantly. For example, in 1997, hospitals realized total margins of -2.0% from Medicare patients, -1.5% from Medicaid patients and 9.7% from private pay patients (predominantly privately insured patients). The private pay margins were high in comparison to the New England Region (6.1%) and the country (5.5%), but relatively modest in comparison to Maine (13.1%) and Vermont (13.0%). Between 1994 and 1997, New Hampshire hospitals prospered from strong operating profits, and in more recent years, benefited from non-operating revenues (primarily from investment income and realized gains). In 1998, operating margins decreased for half of the hospitals and in 1999 for all of them. The median operating margin in 1999 was 1% and the median total margin was 4.4%.

- **Liquidity.** This measures the extent to which hospitals have ready access to relatively liquid resources (cash, short term investments, accounts receivable, inventory) to meet their current obligations and their operating expenses. In terms of two important measures: the current ratio (current assets/current liabilities) and days cash on hand (the number of days the hospital could continue to operate without collecting additional cash), New Hampshire hospitals are stronger than their New England and national counterparts. For example, in 1997, New England and national hospitals had on average 100 days of cash on hand. New Hampshire hospitals had 240 days of cash on hand. [11] By 1998, half of New Hampshire hospitals had 300 or more days of cash on hand; in 1999, days cash on hand decreased slightly. While the 1999 cash flow was still one of strategic flexibility, some strains were beginning to show.

- **Solvency.** New Hampshire hospitals are less reliant on debt and more capable of paying off their debt from their cash flow than other hospitals in New England and the nation. This has not been achieved at the expense of investment in property, plant and equipment as the median age of property plant and equipment is well below national and regional medians.

Efficient and Inexpensive. Low cost is a proxy for efficiency. In 1998, the average cost per inpatient discharge in New Hampshire hospitals ($6,404) was lower than the national average

[11] The average hospital could operate for nearly 8 months without receiving payment for patient services.

($6,702), the New England average ($7,060) and each of the five other New England states: Vermont ($7,052), Maine ($7,624), Massachusetts ($7,833), Rhode Island ($6,509) and Connecticut ($7,055). Low net revenue per discharge is a proxy for price and consumer expense. In 1998, the net revenue per discharge in New Hampshire hospitals ($6,372) was lower than the national average ($6,509), the New England average ($6,711) and four of the New England states: Vermont ($6,777), Maine ($7,624), Massachusetts ($6,501) and Connecticut ($6,736).

The Best of All Worlds? If New Hampshire's hospitals are – in general – financially healthy and low cost then the State might have the best of all possible worlds. An important sector of the State's economy is strong and efficient providing communities with one of their largest employers and with services that are essential to their well being. If these were the only factors to consider the analysis would be complete. Four additional considerations, however, complicated the analysis.

- **High Market Concentration/Few Competitors.** In New Hampshire, most hospitals control their markets and have very few competitors. This lack of competition is not necessarily bad. There is an important difference between having monopoly power and behaving like a monopoly (charging very high prices, lowering output, constructing barriers to entry). As noted above, the costs and net revenues per discharge in New Hampshire are among the lowest in New England. Nonetheless, as "natural monopolies," hospitals have considerable control over the reimbursement rates that will be paid for hospital care in their communities. This is demonstrated by the private pay rates and the cash accumulated by New Hampshire hospitals.

- **Private Pay Rates.** Historically, privately insured patients have reimbursed hospitals at rates considerably higher than the rates that government or the uninsured paid. In 1998, New Hampshire hospitals exhibited losses on their Medicare and Medicaid patients of approximately two percent each. They also posted losses totaling slightly over five percent on bad debt and charity care. These losses on publicly insured patients, bad debt and charity care were offset by positive margins on privately insured patients and by income from accumulated savings (which in 1998 totaled half a billion dollars in cash and marketable securities).

- **Charitable Care.** During this period of prosperity and accumulated cash, the amount of charity or free care provided by hospitals decreased. For example, between 1994 and 1999 charity care (as a percentage of gross patient service revenues) decreased from slightly more than 2% to less than 1.5% – or a 25% reduction. [12] However, the uninsured have not disappeared. A 1999 State survey of the uninsured indicated that approximately 9% (or 96,000) of all of New Hampshire's residents were uninsured (DHHS, 1999). During this same time period, Community Health Centers in New Hampshire reported an increase in the number of uninsured seeking services.

- **Hospitals At Risk.** Averages mask the fact that some hospitals essential to the well being of the State's residents are not faring well. The federally designated Critical Access Hospitals (CAH) will protect some rural hospitals that are at financial risk. However, not all essential hospitals will be eligible or choose to become a CAH.

[12] Compared to a 1995 national database of 500 hospitals, the New Hampshire values are similar to slightly above the national sample. See Kane, N.M. and Wubbenhorst, W.H. "Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption" *Milbank Quarterly*, June 2000.

Community Benefits. The recently enacted Community Benefits legislation requires that non-profit hospitals sit down with individuals from their communities to discuss the hospitals' provision of community benefits. These local discussions and the solutions may be all that that is needed to deal with charitable care, private pay reimbursement and assurances for the future financial stability for most hospitals.

Recommendations for Action

Financial Viability

New Hampshire is fortunate that the majority of its hospitals have exhibited strong financial performance during the period 1993 to 1999. However, 3-5 hospitals' financial performance has not been as strong as the majority. Sociodemographic (e.g., age, income and insurance rates) and geographic (e.g., a sparsely populated area) factors influence the financial health of these institutions. Payer mix is another important indicator of financial viability and it varies from hospital to hospital. A facility that has almost 70% of its revenue coming from Medicare and Medicaid has considerably less flexibility, even if it were able to negotiate favorable rates from private payers.

In rural areas, the scarcity of providers may mean that the hospital is the "safety net" (Ormond, et al 2000). Government and private purchasers are concerned with the financial viability of this key component of the local health care delivery system.

1. ***The State should routinely examine the Medicaid reimbursement rate structure to hospitals.*** New Hampshire's hospitals bring significant value to public payers. On average Medicaid represents 8.4% of the hospitals business. However, for some hospitals it is as much as 15.5%[13]

2. The State should develop a State Rural Health Plan and work with interested hospitals, communities and the federal government to designate small rural hospitals as "Critical Access Hospitals" (CAH). The Office of Community and Public Health is currently developing a State Rural Health Plan. Key elements of the plan will be targeted towards: assisting communities to move towards integrated models of care in an effort to sustain a broad range of services; improving quality of care; helping people obtain care close to home; and ensuring the economic survival of the health care infrastructure. It will also identify the needs of hospitals as they transition to a different model of care that provides "critical access" to their communities and fosters the development of regional and local health service networks. Finally, the plan will allow the State, hospitals and communities to continue to work towards designation of underserved areas, such as Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs), and Medically Underserved Populations (MUPs) to maximize federal support.

The Critical Access Hospital (CAH) program is a major component of the State Rural Health Plan. CAH designation may bolster the financial status of small rural hospitals by providing cost-based reimbursement from Medicare. This federal program (designed as a "remedy" to the financial effects of the Balanced Budget Act) recognizes that these hospitals are often the sole providers of health care in their communities. In return for this designation, a hospital agrees to have no more than 25 beds in service (15 acute care and 10 "swing beds") and a yearly average length of stay that does not exceed 96 hours. Communities retain their primary health care provider and access to emergency services, while the State is able to monitor whether or not the uninsured are receiving health care.

[13] See Appendix B "NH Acute Care Hospitals Payor Mix – 1999 Percent of Discharges" in *Present and Future Challenges Affecting New Hampshire's Hospitals* that appears after this report in the conference notebook.

Community Benefits

New Hampshire's community benefit legislation (see the Reference section for a copy of the legislation) is both timely and valuable, builds on New Hampshire's tradition of local problem solving, and offers an opportunity for health care charitable trusts to highlight the contributions they make to their communities. It offers a non-regulatory solution to some of the economic and public health issues that confront many communities. The legislation offers a forum for addressing local health care needs that permits informed discussion between health care charitable trusts – in this case hospitals – and their communities. The theme of a series of statewide workshops sponsored by the DHHS and Attorney General's Office, held to assist charitable trusts in implementing SB 69, was and continues to be, education, involvement and measurement.

In 2001, the Department of Health and Human Services and the Dartmouth Hitchcock Alliance will release the *Regional Community Profiles*, [14] a set of population health profiles of each of the State's 24 health care service areas. Other local, State and federal reports supplement these profiles. The financial and economic analyses permit each community to assess the capacity of their hospital to work with them to address one or more of the local problems. Community forums, workshops and data will allow education, involvement and measurement to be the cornerstones for moving the community benefits statute forward in a manner that is consistent with how New Hampshire communities operate.

1. ***Hospital administrators and trustees should review their charitable spending (free care) policies and programs relative to their financial performance each year and undertake efforts to quantify the value of their community benefit programs.*** When the State considered the community benefit legislation, the lack of measurement of what health care charitable trusts did for their communities was emphasized in the deliberations. SB 69 laid out a process by which health care charitable trusts could account to their stakeholders - the public - on how they achieve their missions. The legislation is not prescriptive; it offers a range of activities that can be counted towards "community benefit." More importantly, it allows for the measurement of these activities.

2. Hospitals should participate and invest in community-based partnerships to: identify preventable threats to the public's health; determine the health needs of their service area; and develop community benefit plans to address these needs. Hospitals have a unique opportunity to increase their role in improving the health of the people of New Hampshire by taking action to reduce preventable deaths, disease, disability and disparities in health status. The *Healthy New Hampshire 2010* goals offer a starting point for community dialogue. [15]
The plan includes goals in eleven focus areas:

[14] The *Regional Community Profiles* consists of a set of public health indicators and data on health insurance coverage from the NH *Health Insurance and Coverage Access Survey* organized by Hospital Service Areas. They are expected to be released in early 2001 and should prove useful in current and future community needs assessments and evaluation of community benefit activities.
[15] A copy of the plan and goals will be released in January and can be found at the website address: www.HealthyNH2010.org

Access to Quality Health Services	Injury and Violence Prevention
Alcohol, Tobacco, and Other Drugs	Maternal, Infant and Child Health
Cancer and Chronic Conditions	Mental Health
Environmental Health	Nutrition and Physical Activity
Heart Disease, Stroke and Diabetes	Reproductive and Sexual Activity
Immunization and Infectious Disease	

3. ***The State should make market information and health status data available for use in local discussions on health needs and community benefits.*** The Internet has proven to be a quick and inexpensive tool for dissemination of information. The DHHS, since the completion of the first phase of the health care planning process (which culminated in the publication of the *Guidelines for Change*), has posted reports associated with the implementation phase on its website. [16] Efforts are underway at the Office of the Attorney General to provide community members with community benefit plans filed with the Charitable Trust Division. [17] Reports on the State's health plans (e.g., their financial status and annual filings) should also be available on the Internet in the future.

Audited financial statements (used in the hospital and Community Health Center studies) contain a wealth of information about an organization; however, most people are unfamiliar with the financial analysis necessary to increase the utility of that information. This can be particularly true for citizen volunteers on boards of nonprofit community-based organizations. A better understanding of the information (e.g., what it can and cannot tell us) can also go a long way towards ensuring that the information is used responsibly. Workshops for Health District Council members, board members and trustees, and other interested parties would aid in the understanding and responsible use of the information contained in this report.

While the Internet has proven to be a quick and inexpensive tool for dissemination of information, not everyone has access to the Internet nor is it a substitute for the face-to-face discussions necessary to foster community involvement in their health care charitable trusts. Participants in the community benefit workshops held in 2000 requested follow-up regional meetings to share what was occurring in their communities. The Health District Councils, the DHHS' advisors for health policy discussion and development, have expressed interest in following the implementation of the community benefit statute. Health District Council sponsorship of "best practices" forums in communities around New Hampshire would offer the opportunity to learn and share information.

Access to Care

Resources and health care needs are not evenly distributed across this State, adding to the burden some providers face and raising the question as to whether all New Hampshire citizens have access to the right care in the most appropriate setting. Costly emergency room services are a poor substitute for "front end" access to primary care. While studies have shown that many of the

[16] The website contains the *Guidelines for Change*, results of the household insurance survey and the reports that were released as part of the market analysis. It also allows the DHHS to provide the detailed background information that went into developing these reports that would be of interest to some, but not all, members of the public. Future reports on the uninsured and results of an employer survey should be available late in 2001.

[17] At this point in time, a list of those health care charitable trusts that have filed their plans and needs assessments is on the Charitable Trust Division website. Anyone can request copies of the filings. **http://webster.state.nh.us/nhdoj/CHARITABLE/char.html**

uninsured receive some health care, there is no good information on when or where that care is received and whether or not it was timely and adequate.

Despite a robust economy, 96,000 people or approximately 9% of the State's population lack health insurance. [18] Community Health Centers have experienced a 51% increase in their caseloads since the mid-1990s. [19] Throughout each of New Hampshire hospital's service areas there are members of the community without insurance. While the statewide average of people without health insurance is 9%, this average masks the fact that 15 out of 24 hospital service areas have rates of un-insurance between 10-20% of the population. Far more NH residents lack dental coverage - 25.7% - but this average masks even more significant hospital service area variation. Seventeen out of 24 hospital service areas have rates of dental un-insurance between 26-55%.

1. ***Community hospitals, hospital systems, providers, businesses, foundations and community organizations should continue efforts to enroll all those eligible for Medicaid and the State Children's Health Insurance Program (SCHIP). Efforts should also continue to expand health insurance coverage to people who cannot afford it.*** Hospitals are an important source of referrals for Medicaid and SCHIP. Expanded insurance coverage will give more patients a source of payment, which could improve the financial status of some hospitals and reduce the burden on emergency rooms.

The Adult Coverage Subcommittee of the Healthy Kid's Corporation created by SB 183 is currently exploring options for expanding insurance coverage to adults. A report will be delivered to the Legislature by the year's end. A study of the State's uninsured and what it would take for them to be able to participate in health insurance is also underway. This is part of the Health Resource Services Administration's (HRSA) State Planning Grant initiative. Results of this study will be released in a report that will be issued in the fall of 2001.

The federal government should be encouraged to: 1) expand the age limit for SCHIP from 18 to 24; and 2) allow the SCHIP state allocation to be used to expand coverage to low-income working adults.

2. ***Community hospitals, hospital systems, providers, businesses, foundations and community organizations should develop partnerships to provide community-based, coordinated care management programs to people without medical or dental insurance.*** There are several locales in the State where community-based programs organize and leverage provider donated or reduced-fee care. They are led by the hospital in that community or a freestanding entity. Participants receive an "insurance-like" card and benefits from providers that agree to participate. [20] Case management is an integral part of these programs. Examples of these efforts include

[18] *Health Insurance Coverage and the Uninsured in New Hampshire* is available on the DHHS website. **www.dhhs.state.nh.us**

[19] See *Present and Future Challenges Facing New Hampshire's Community Health Centers* in *Strengthening the Safety Net: A Financial Analysis of New Hampshire's Community Health Centers* available on the DHHS website. **www.dhhs.state.nh.us**

[20] The key to these programs is the card that participants receive that enables them to access care through various providers. NH's Community Health Centers, through efforts such as the Community Health

Seacoast HealthNet, HealthLink in the Laconia area (associated with Lakes Region General Hospital), and Greater Derry Community Health Services (associated with Parkland Hospital). In addition to hospital and physician donations, the DHHS' Community Grant Program has been an important source of funds for start-up and expansion of these innovative medical and dental programs (e.g., HealthLink and Greater Derry Community Health Services). These local initiatives allow hospitals, physicians, health and social service agencies, businesses and foundations to work collaboratively to improve access to health care services.

Monitoring a New and Evolving Health Care System

One of the purposes of the State Health Plan and its associated Health District Councils, is to allow the State, communities, firms and individuals to assess how the health care system is changing and to determine whether those changes are desirable from a public and/or private perspective.

Timely and accurate data is needed in order to continue to assess the effectiveness, efficiency and financial viability of New Hampshire's community hospitals. Information presented in the aggregate can mask both "high" and "low performers." If there are fundamental risk points in the State's community hospital system (i.e., "difficult" markets that lack the necessary resources due to socioeconomic or geographic characteristics) they should be identified. The impact of State and federal policy decisions should also be assessed.

Other types of providers - whether owned fully, or in part, by a hospital or freestanding entities - are delivering services that traditionally were performed within the walls of hospitals. This means that traditional sources of data are no longer adequate to describe the health care market.

1. ***The State, together with market participants, should continue to monitor the impact of market forces on the structure, capacity, and financial stability of the State's community hospitals, as well as the impact of hospital market conduct on other sectors of the health care system.*** Annual financial analyses, household insurance surveys, quantification of charity care offered by other community providers, and description of the relationships among providers and health plans will enhance the ability of the Legislature and policymakers to make fact-based decisions. Expert technical assistance and consultation should be utilized to incorporate annual financial analyses of certain sectors of the State's health care market, together with dissemination of results, into the ongoing operations of the DHHS. Other questions raised by this project that merit attention are:

- Where do the uninsured get care and when do they get it? Are we paying too much for expensive emergency room care and not investing enough in primary care?
- What are the outcomes of consolidation and mergers in the insurance market on hospitals' financial performance? Insurance premiums?
- How has consolidation on the provider side affected insurance premiums? Access to care?
- Will Critical Access Hospital designation maintain providers in rural areas?

Access Network (CHAN), disease management programs and social service provision, also provide coordinated care management to people without medical and dental insurance.

- How are providers in the 25th percentile (of financial indicators) doing from one year to the next?
- How are the effects of, and remedies for, the Balanced Budget Act playing out in the hospital market?

2. ***The State, together with market participants, should expand research and monitoring efforts to other sectors of the State's health care system: the insurance, physician and nursing home markets.*** Information and data available on the hospital sector pointed out the dearth of information and data on other sectors, such as the insurance and physician markets. Without a systematic way to track providers and other players, the true story of what is occurring in the State's health care market will be lost. Systematic tracking requires the continued collaboration and concerted efforts of market participants and the Interagency Workgroup - Department of Health and Human Services, Department of Insurance and the Office of the Attorney General - the three State agencies charged with the monitoring, financing and regulation of the health care market.

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