The Health of New Hampshire's Community Hospital System

A Financial and Economic Analysis

Preface, Purpose and Introductory Materials




Office of Planning and Research
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Section III– Assessing the Competitiveness of New Hampshire's Health Care Markets: A Focus on Hospitals
Executive Summary




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SECTION III

Assessing the Competitiveness of New Hampshire's Health Care Markets: A Focus on Hospitals

Executive Summary

Center for Health Economics Research

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Done In Cooperation with
New Hampshire Department of Health and Human Services
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Assessing the Competitiveness of New Hampshire's Health Care Markets: A Focus on Hospitals

Executive Summary

History of the New Hampshire Health Plan

In 1995, in response to changes in the health care system, the Department of Health and Human Services (DHHS) drafted legislation that was approved and signed into law that directs the Department to prepare "a comprehensive and coordinated system of health and human services as needed to promote and protect the health, safety and well-being of the citizens of New Hampshire." (RSA 126A) The Department responded by creating a statewide Health Care Planning Process, the goal of which was to develop a New Hampshire State Health Plan. Four years after its inception, the Health Care Planning Process entered its initial implementation phase, and DHHS contracted with staff at the Center for Health Economics Research (CHER) in Waltham, Massachusetts to study the structure and performance of the health care markets in New Hampshire.

Scope and Purpose of the Project

The project's principal research agenda consisted of three separate components. The first component was to determine the overall competitiveness of the New Hampshire health care markets. This task involved the following preliminary steps:

- defining what competition in health care means,

- describing the strengths and limitations of competition in health care,
- creating a set of indicators to measure competition,
- characterizing the provider and insurer markets in New Hampshire,
- measuring competition in the state's provider and insurer markets, and
- analyzing changes in competitiveness in New Hampshire over time.

Having identified the extent of competition in New Hampshire's health care markets, the second component was to evaluate the effects of competition on the performance of the provider and insurer markets. This task involved measuring the impact of market concentration on the following performance domains:

- provider costs, prices and profits,
- insurance premiums,
- formation of integrated provider networks,
- access to health care services,
- service utilization, and
- health care outcomes.

The third major component was to develop an information system that could be used to monitor and evaluate the competitiveness of the state's health care markets in the future. This assignment required us to:

- create a set of standardized indicators that can be used to measure competition,
- create a set of standardized measures that can be used to evaluate the effects of market competition, and
- design an information system that can be used for monitoring and evaluating changes in health care markets.

The initial scope of work was eventually narrowed by focusing on the hospital sector. A hospital focus proved necessary because the data required to conduct an impact

analysis on other sectors of the health care system (e.g., insurers, physicians, community health care centers, nursing homes, etc.) were simply not available. Only the hospital sector offered sufficient, consistent and reliable information to study its structure, conduct, and performance in a rigorous manner. At the same time, the scope of the study was broadened by taking into account a much fuller range of structure and conduct characteristics than were originally considered. Most measures of competition or market share fail to capture important horizontal linkages among hospitals, vertical linkages among hospitals and other providers, and linkages among hospitals and insurers that influence performance – all of which will play a critical role in determining the competitiveness and performance of the health care system.

Major Findings of the Study

The major findings of the study are divided into two sets: those relating to hospital market structure and those highlighting hospital conduct and performance. The main findings regarding the **structure of hospital markets** can be summarized as follows:

- Most New Hampshire hospitals enjoy very strong market positions in their local geographic and service markets. The typical hospital treats over half of the inpatient admissions in its market. In 1998, five hospitals controlled over 70 percent of their markets' inpatient admissions. (See Pie Charts and Map 4-1.)
- Primary and hospital outpatient service markets tend to be more concentrated than tertiary and secondary care service markets. The typical hospital outpatient market is characterized by a single provider controlling over three-quarters of all hospital outpatient visits. (See Map 4-3.)
- Most hospital markets in New Hampshire are small and non-overlapping, with a low population density. (See Map 4-1.)

- Many hospitals exhibit low occupancy rates, especially smaller ones competing with a dominant hospital in its market. The average unweighted hospital occupancy ratio in 1998 was 48 percent. Twelve of the 26 hospitals in New Hampshire had only one-third of their beds filled on any given day in 1998. (See Table 4-1.)
- Markets in the central, southern and seacoast regions of the state have more competitors. But admissions in these markets remain concentrated in a single dominant hospital.

The main findings of the report regarding the **conduct and performance of hospitals** in New Hampshire can be summarized as follows:

- Hospitals in New Hampshire exhibit the lowest average costs in the region. Average casemix and wage adjusted costs per discharge in New Hampshire in 1998 were $6,404, compared with $7,060 regionally and $6,702 nationally. (See Table 7-1.)
- A few smaller hospitals exhibited average costs in excess of $8,000 in 1998, well above the state, regional and national averages. (See Table 7-4.)
- Hospitals are generating relatively higher margins (net gains or losses divided by total payment) from private payers. Hospital margins from private payers in New Hampshire were 9.7 percent in 1998, compared with 6.1 percent regionally and 5.5 percent nationally. (See Table 7-2.)
- Average net revenues (excess of payment over costs) in New Hampshire were the second lowest in the region. In 1998, average net revenue in New Hampshire adjusted for casemix and wage differences was $6,372, compared with $6,711 regionally and $6,509 nationally. (See Table 7-1.)
- Most hospitals in New Hampshire have been enjoying relatively high annual net incomes and exhibit remarkably solid balance sheets. In 1998, hospitals in New Hampshire enjoyed an average total margin (total revenues over total expenses) of 6.9 percent, compared with 4.5 percent regionally and 5.8 percent nationally. (See Table 7-1.)
- In 1998, New Hampshire hospitals exhibited losses on their Medicaid and Medicare patients of approximately two percent each. They also posted losses on uncompensated care (bad debt plus free care) of slightly over five percent. These losses on publicly insured patients and uncompensated care were offset by positive profits on privately insured patients and by income from accumulated savings. (See Table 7-2.)

- Hospitals have created a variety of horizontal and vertical linkages with providers that may potentiallserve to reinforce market concentrations. (See Tables 6-1, 6-2, and 6-3)
- Managed care penetration remains relatively low in most markets in New Hampshire. The HMO share of discharges across hospital markets in 1998 was 20 percent, ranging from near zero in some northern markets to half of all discharges in the less concentrated markets in the southern regions of the state. (See Table 6-5.)
- Hospitals appear to have been successful in avoiding the discounts and risk sharing arrangements typically associated with managed care plans. While HMO share of admissions ranged from 20 to 50 percent for some markets, the actual share of hospital revenue exposed to risk sharing or capitated contracts was less than 10 percent on average. (See Table 6-5.)

Major Conclusions

Based on the findings of the report with regard to the structure, conduct and performance of New Hampshire hospitals, we draw the following major conclusions:

- Many hospitals in New Hampshire are 'natural monopolies' due to their geographic dispersion and the low population density in most areas. As such, they exhibit substantial efficiency gains through larger size with smaller providers at a financial cost disadvantage. They also appear to enjoy considerable power in determining payments if they choose to exercise it.
- Most markets are segmented with smaller facilities treating less complicated cases and more complex cases flowing naturally to the few larger tertiary facilities in the state. This natural market segmentation creates further efficiencies in the allocation of resources across hospitals in the state.
- Most hospitals do not appear to be competing for patients through the purchase of expensive and duplicative equipment, but rather triage more complex patients to regional care centers.
- A few smaller community hospitals with low occupancy rates in otherwise concentrated markets are relatively costly, yet do not appear to be at risk of closing.
- Most New Hampshire hospitals appear to be using their positive net revenues from private payers to cross-subsidize losses on public payers and the uninsured.

- Hospitals appear to have sufficient net revenues to support more charity care, though demand for charity care varies across hospital markets. (See Table 7-6)
- Hospitals could reduce markups to private payors without risking provision of free care or exiting the market through bankruptcy. (See Table 7-6)

Policy Implications

Promoting Supply-Side Competition

Based on these conclusions, promoting supply-side competition is unlikely to lower privately contracted 'prices' significantly due to providers' potential market power. Despite New Hampshire hospitals deriving higher gains from commercial payers, simply adding more local care alternatives will not guarantee lower 'prices' for many patients and insurers. Local demand is too sparsely distributed to support more acute facilities, as evidenced by the already small bedsizes and occupancy rates of many of the state's acute care facilities.

Furthermore, distributing volumes to other providers is likely to have four undesirable impacts. These are:

- First, procedure volumes per provider, already relatively low in some facilities, will fall, endangering quality and raising costs further. Minimum quality levels dictate reasonably sized institutions that can financially support the range of costly diagnostic and therapeutic equipment necessary to modern acute medicine. In addition, surgicenters would certainly be less costly than acute facilities for the procedures they perform, and their entry into the market should drive down prices for similar procedures performed in nearby acute facilities. But their effect on acute care providers would most likely be higher average costs for non-surgical and more complex surgeries.
- Second, non-profit hospitals will likely feel forced through competition to regain revenues or reduce costs by reducing care, by encouraging readmissions, and/or by upcoding diagnoses for DRG payment. Reducing care has quality implications.

- Third, supply-side competition may induce hospitals to cut back on free care when volumes and revenues are threatened. If competition were to come from new acute facilities or surgicenters, neither of these groups could be expected to provide much, if any, charity care -- particularly as start-up operations. Policy makers should expect some negative response to heightened competition in restricted access to acute inpatient and outpatient institutional care among the under- and uninsured.
- Fourth, heightened supply-side competition may result in closures and possibly unstable access to care. A natural outcome of competition is market exit, not just lower prices. Heightened competition could drive out a provider located in a poorer community with more uninsured. This may be "efficient" from an industry perspective but not optimal from a societal perspective given that health care is valued by all. The trade-off between competitive efficiency and access can be severe in more rural states like New Hampshire where the population is sparsely distributed and terrain and weather are serious factors affecting access to care.

Promoting Demand-Side Competition through Managed Care

Managed care can redress market failures in two ways. First, by overseeing the care patients receive, managed care can reduce unnecessary care and lower payer costs. Second, by representing a large number of subscribers, managed care can consolidate their market power and negotiate lower prices with providers. Yet, without state intervention, managed care is unlikely to instill greater competition in most New Hampshire markets. HMOs will have difficulty negotiating anything other than minor price discounts with most providers given the concentrated hospital market structure and the networks and alliances these providers have entered. This is true even in the Seacoast and Southcentral markets of Manchester and Nashua. At best, six to eight hospitals might be candidates for instilling price competition through HMO activity. The rest of the providers appear to be too dispersed or serving very different kinds of patients to be targets for managed care.

Community-Based Solutions

If the promotion of supply- or demand-side solutions holds little promise for dealing with problems in the market, then non-market interventions should be considered. In most other States, government is the only non-market intervention that can be employed. Fortunately, New Hampshire – through its community benefits legislation SB 69 - has created an opportunity for communities to act as the first and perhaps only place that these questions need to be resolved. The community benefits legislation requires that by 2001 all non-profit health care providers with $100,000 or more in their total fund balance must complete a needs assessment of the communities that they serve, conduct meetings with those communities to discuss what the provider has done in the past to meet community needs and what it plans to do in the future and then submit that plan to the Attorney General's Office. The point at which hospitals sit down with individuals from their communities to discuss the hospitals' provision of community benefits is an ideal first line venue for reviewing the issues raised above.

Areas of Future Research

This project constitutes one of the first extensive investigations of the structure of the New Hampshire hospital industry and the extent to which the system is meeting both the private and social objectives. Future research should:

- continue to monitor the hospital industry, particularly in light of the potentially significant impact that the community benefits legislation may have on the industry;
- place the behavior of the hospital sector in the larger context of total state health care expenditures;

- analyze physician services and their linkages with other providers; and
- analyze the health insurance and health maintenance organization market.

TABLES

From:

Executive Summary - ***Assessing the Competitiveness of New Hampshire's Health Care Markets: A Focus on Hospitals***

Center for Health Economics Research for the Office of Planning and Research, New Hampshire Department of Health and Human Services; December, 2000

Table 4-1

Profile of New Hampshire's 26 Acute Care Hospitals

Hospital Name	Town	Region	Share of Discharges	Number of Discharges	Number of Beds	Patient Days	Occupancy Ratio*	Teaching Affiliation	Ownership	Patient Casemix	Share of Total Discharges by Type of Payer		
											Medicare	Medicaid	Self-Pay
Alice Peck Day Memorial Hospital	Lebanon	Central Western	0.79%	902	32	2,515	22%	No	Non-Profit	0.79	26%	6%	3%
Androscoggin Valley Hospital	Berlin	North Country	1.74	1,988	64	13,386	57%	No	Non-Profit	0.95	56	15	5
Catholic Medical Center	Manchester	Central	7.04	8,032	213	50,798	65%	No	Non-Profit	1.92	54	7	5
Cheshire Medical Center	Keene	Southwestern	4.72	5,377	141	27,033	53%	No	Non-Profit	1.04	43	10	5
Concord Hospital	Concord	Central	9.29	10,590	176	44,795	70%	Yes	Non-Profit	1.20	34	7	4
Cottage Hospital	Woodsville	North Country	0.90	1,025	34	4,549	37%	No	Non-Profit	1.14	56	11	4
Elliot Hospital	Manchester	Central	11.29	12,877	225	45,241	55%	No	Non-Profit	0.93	25	11	4
Exeter Hospital, Inc.	Exeter	Seacoast	4.17	4,756	80	15,520	53%	No	Non-Profit	1.05	33	8	5
Franklin Regional Hospital	Franklin	Central Eastern	1.45	1,659	49	6,547	37%	No	Non-Profit	0.95	55	13	4
Frisbie Memorial Hospital	Rochester	Seacoast	3.09	3,519	70	13,904	54%	No	Non-Profit	0.93	43	16	4
Huggins Hospital	Wolfeboro	Central Eastern	1.44	1,642	55	10,974	55%	No	Non-Profit	0.99	52	10	3
Lakes Region General Hospital	Laconia	Central Eastern	4.35	4,955	117	24,943	58%	No	Non-Profit	1.08	43	11	5
Littleton Hospital	Littleton	North Country	1.46	1,670	49	4,575	26%	No	Non-Profit	0.96	39	9	6
Mary Hitchcock Memorial Hospital	Lebanon	Central Western	15.24	17,373	322	86,671	74%	Yes	Non-Profit	1.57	35	8	4
Memorial Hospital	North Conway	Central Eastern	1.40	1,594	35	6,030	47%	No	Non-Profit	0.90	38	14	6
Monadnock Community Hospital	Peterborough	Southwestern	1.80	2,056	62	8,370	37%	No	Non-Profit	0.78	32	8	4
New London Hospital Assoc.	New London	Central Western	1.18	1,348	35	6,600	52%	No	Non-Profit	0.95	55	7	3
Parkland Medical Center	Derry	Seacoast	3.30	3,767	59	13,149	61%	No	Profit	0.98	28	6	3
Portsmouth Regional Hospital	Portsmouth	Seacoast	5.38	6,136	179	37,297	57%	No	Profit	1.02	35	6	3
So NH Regional Medical Center	Nashua	Southwestern	6.85	7,811	171	24,127	39%	No	Non-Profit	0.90	22	10	7
Speare Memorial Hospital	Plymouth	Central Eastern	0.88	1,005	28	3,382	33%	No	Non-Profit	1.05	41	10	6
St. Joseph Hospital	Nashua	Southwestern	5.24	5,976	135	28,775	58%	No	Non-Profit	1.03	35	3	5
Upper Connecticul Valley Hospital	Colebrook	North Country	0.41	464	20	1,956	27%	No	Non-Profit	0.94	56	13	4
Valley Regional Hospital	Claremont	Central Western	1.59	1,810	43	6,522	42%	No	Non-Profit	0.96	40	17	6
Weeks Memorial Hospital	Lancaster	North Country	0.79	904	38	6,328	46%	No	Non-Profit	0.97	57	11	3
Wentworth-Douglass Hospital	Dover	Seacoast	4.20	4,791	115	17,880	43%	No	Non-Profit	1.07	42	7	4
Unweighted Average			3.82	4,386	98	19,687	48%			1.04	40	10	4
Median			2.44	2,788	63	13,268	52%			0.97	40	10	4
Minimum			0.01	464	20	1,956	22%			0.78	0	3	0
Maximum			15.24	17,373	322	86,671	74%			1.92	57	17	7

NOTE: Occupancy ratio measures the number of beds actually used by admitted patients divided by the number of staffed acute care beds throughout the year.

SOURCE: *AHA Annual Survey of Hospitals*, 1998. Discharge shares and patient casemix are based on the *New Hampshire Hospital Discharge File*, 1998.

Table 6-1

New Hampshire Hospitals' Centralized Organizational Structure

Hospital	Is Hospital a Subsidiary of a Holding Company?	Is Hospital Member of a Health Care System?	Is Hospital Member of an Alliance?	Is Hospital Member of a Network?	Does Hospital Operate a Subsidiary?
Alice Peck Day Memorial Hospital	Yes	No	No	No	No
Androscoggin Valley Hospital	Yes	Yes	Yes	Yes	No
Catholic Medical	Yes	No	No	No	No
Cheshire Medical Center	Yes	Yes	Yes	Yes	Yes
Concord Hospital	Yes	Yes	Yes	..	Yes
Cottage Hospital	No	No	Yes	Yes	No
Elliot Hospital	Yes	No	No	No	No
Exeter Hospital, Inc.	Yes	No	No	No	No
Franklin Regional Hospital	No	No	No	Yes	No
Frisbie Memorial Hospital	No	No	Yes	No	Yes
Huggins Hospital	No	No	No	No	No
Lakes Region General Hospital	No	No	No	Yes	No
Littleton Hospital	No	No	Yes	No	No
Mary Hitchcock Memorial Hospital	Yes	Yes	Yes	No	Yes
Memorial Hospital	No	No	No	No	Yes
Monadnock Community Hospital	No	Yes	No	No	Yes
New London Hospital Assoc.	Yes	Yes	No	No	Yes
Parkland Medical Center	No	Yes	No	No	No
Portsmouth Regional Hospital	Yes	Yes	Yes	No	Yes
So NH Regional Medical Center	Yes	Yes	Yes	Yes	No
Speare Memorial Hospital	No	No	No	No	Yes
St. Joseph Hospital	No	Yes	Yes	No	Yes
Upper Connecticut Valley Hospital	Yes	Yes	Yes	No	No
Valley Regional Hospital	Yes	Yes	Yes	No	No
Weeks Memorial Hospital	No	No	Yes	No	No
Wentworth-Douglass Hospital	No	No	No	No	Yes
Yes/No Counts	**13/13**	**12/14**	**13/13**	**6/19**	**11/15**

NOTES:
A holding company is any company that controls the management of one or more companies by virtue of its ownership of securities and/or its right to appoint directors.

A health care system is a corporate body that owns or manages health-related or non-health-related provider facilities, including freestanding facilities and subsidiaries.

An alliance is a formal organization owned by its members that works on behalf of its individual members in the provision of services.

A network is a group of hospitals, physicians, other providers, insurers and/or community agencies that work together to coordinate and deliver a broad range of services to the community.

SOURCE: *AHA's Annual Survey of Hospitals*, 1998

Table 6-2

New Hampshire Hospitals' Physician Practice Affiliations

	Does Hospital Participate in a:							
Hospital	Independent Practice Association	Group Practice Without Walls'	Open Physician-Hospital Organization	Closed Physician-Hospital Organization	Management Service Organization	Integrated Salary Model	Equity Model	Foundation
Alice Peck Day Memorial Hospital	No	No	Yes	No	No	No	No	No
Androscoggin Valley Hospital	No	No	No	No	No	No	No	Yes
Catholic Medical	No	No	Yes	No	Yes	No	No	No
Cheshire Medical Center	No	No	No	Yes	No	No	No	No
Concord Hospital	No	No	No	No	Yes	Yes	No	No
Cottage Hospital	No	No	Yes	No	No	No	No	No
Elliot Hospital	No	No	Yes	No	Yes	No	No	No
Exeter Hospital, Inc.	No	No	No	Yes	No	No	No	No
Franklin Regional Hospital	No	No	Yes	No	No	No	No	No
Frisbie Memorial Hospital	Yes	No	Yes	No	No	Yes	No	Yes
Huggins Hospital	No	No	Yes	No	No	No	No	No
Lakes Region General Hospital	No	No	Yes	No	No	Yes	No	No
Littleton Hospital	No	No	No	No	No	No	No	No
Mary Hitchcock Memorial Hospital	No	No	No	No	No	No	No	Yes
Memorial Hospital	No	No	No	No	No	No	No	Yes
Monadnock Community Hospital	No	No	No	No	No	No	No	No
New London Hospital Assoc.	No	No	Yes	No	No	No	No	No
Parkland Medical Center	No	No	No	No	No	No	No	No
Portsmouth Regional Hospital	No	No	Yes	Yes	No	Yes	No	No
So NH Regional Medical Center	No	No	Yes	No	No	Yes	No	No
Speare Memorial Hospital	No	No	Yes	No	No	No	No	No
St. Joseph Hospital	No	No	Yes	No	No	Yes	No	No
Upper Connecticut Valley Hospital	No	No	No	No	No	No	No	No
Valley Regional Hospital	No	No	No	No	Yes	No	No	No
Weeks Memorial Hospital	No	No	No	No	No	Yes	No	No
Wentworth-Douglass Hospital	Yes	No	Yes	No	No	No	No	No
Yes/No Counts	**2/24**	**0/26**	**14/12**	**3/23**	**4/22**	**7/19**	**0/26**	**4/22**

NOTES:

An independent practice association (IPA) is a legal entity that holds managed care contracts and then contracts with physicians to provide care.

A group practice without walls exists when hospitals sponsor the formation of or provide capital to physicians to establish a quasi group to share administrative expenses while remaining independent practitioners.

A physician-hospital organization (PHO) is a joint venture between a hospital and all members of the medical staff who wish to participate. The PHO can act as a unified agent in managed care contracting, own a managed care plan, own and operate ambulatory care centers or ancillary service projects, or provide administrative services to its physician members.

A management service organization (MSO) is a corporation owned by the hospital or a physician/hospital joint venture that provides management services to one or more medical group practices.

SOURCE: *AHA's Annual Survey of Hospitals* , 1998

Table 6-3

New Hampshire Hospitals' Sub-Acute Care Provider Affiliations

	Does Hospital or Hospital's Network or Health System Operate a:											
Hospital	Skilled Nursing Facility	Intermediate Care Facility	Home Health Agency	Long Term Care Facility	Freestanding Outpatient Care Facility	Testing and Imaging Facility	Rehab Facility	Sports Medicine Facility	Hospice Facility	Adult Day Care Facility	Retirement Facility	Assisted Living Facility
Alice Peck Day Memorial Hospital	Yes	Yes	No	No	Yes	Yes	No	No	Yes	No	Yes	Yes
Androscoggin Valley Hospital	Yes	Yes	Yes	No	No	Yes	No	No	Yes	No	No	No
Catholic Medical	No	No	Yes	No	No	Yes	Yes	Yes	Yes	Yes	No	Yes
Cheshire Medical Center	No	No	Yes	No	No	Yes	Yes	Yes	Yes	Yes	No	No
Concord Hospital	No	No	No	No	Yes	Yes	No	Yes	Yes	No	No	Yes
Cottage Hospital	Yes	Yes	No	No	No	Yes	No	No	No	No	No	No
Elliot Hospital	No	No	Yes	No	No	Yes	No	Yes	Yes	Yes	Yes	Yes
Exeter Hospital, Inc.	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	No	No
Franklin Regional Hospital	Yes	Yes	Yes	No	No	Yes	No	No	Yes	No	No	No
Frisbie Memorial Hospital	No	No	No	No	No	Yes	No	Yes	Yes	No	No	No
Huggins Hospital	Yes	No	No	No	No	Yes	No	No	No	Yes	Yes	Yes
Lakes Region General Hospital	No	No	No	No	No	Yes	No	No	Yes	Yes	No	No
Littleton Hospital	No	No	No	No	No	Yes	No	No	Yes	No	No	No
Mary Hitchcock Memorial Hospital	No	No	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No
Memorial Hospital	No	Yes	No	No	No	Yes	No	No	No	Yes	No	No
Monadnock Community Hospital	No	No	Yes	No	No	Yes	No	No	Yes	No	No	No
New London Hospital Assoc.	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	No	No
Parkland Medical Center	No	No	No	No	No	Yes	No	No	No	No	No	No
Portsmouth Regional Hospital	No	No	Yes	No	No	Yes	No	No	Yes	No	No	No
So NH Regional Medical Center	No	No	Yes	No	No	Yes	No	Yes	Yes	Yes	No	No
Speare Memorial Hospital	No	No	No	No	No	Yes	No	No	Yes	No	No	No
St. Joseph Hospital	No	No	Yes	No	Yes	Yes	Yes	No	Yes	Yes	No	No
Upper Connecticut Valley Hospital	No	No	Yes	No	No	Yes	No	No	No	No	No	No
Valley Regional Hospital	Yes	No	Yes	No	Yes	Yes	No	Yes	Yes	Yes	No	Yes
Weeks Memorial Hospital	No	No	Yes	No	No	Yes	No	Yes	Yes	No	No	No
Wentworth-Douglass Hospital	No	No	Yes	No	No	Yes	No	Yes	Yes	No	No	No
Yes/No Counts	**8/18**	**7/19**	**16/10**	**0/26**	**6/20**	**26/0**	**4/22**	**12/14**	**21/5**	**9/17**	**3/23**	**6/20**

SOURCE: *AHA's Annual Survey of Hospitals* , 1998

Table 6-5

Managed Care Contracts and Revenue Share by Hospital

Hospital	Does Hospital Contract with an HMO?	Number of HMO Contracts	Does Hospital Contract with a PPO?	Number of PPO Contracts	Does Hospital Have Risk Sharing Contract with Employer Group?	Number of Lives Covered under Capitation	Percent of Net Patient Revenue Capitated	Percent of Net Patient Revenue on a Shared Risk Basis	HMO Share of Discharges
Alice Peck Day Memorial Hospital	Yes	4	Yes	5	No	0	0%	15%	26%
Androscoggin Valley Hospital	Yes	3	No	0	No	0	0%	7%	10%
Catholic Medical	Yes	5	Yes	26	No	27,020	3%	1%	18%
Cheshire Medical Center	Yes	6	Yes	5	Yes	15,000	19%	19%	19%
Concord Hospital	Yes	4	Yes	21	No	28,000	15%	15%	30%
Cottage Hospital	Yes	6	Yes	12	No	0	0%	10%	11%
Elliot Hospital	Yes	5	Yes	22	No	27,020	4%	2%	34%
Exeter Hospital, Inc.	Yes	6	Yes	4	No	2,500	12%	2%	7%
Franklin Regional Hospital	Yes	3	Yes	15	No	0	0%	12%	19%
Frisbie Memorial Hospital	Yes	4	Yes	10	Yes	4,800	4%	0%	21%
Huggins Hospital	Yes	2	Yes	8	No	0	0%	2%	18%
Lakes Region General Hospital	Yes	2	Yes	2	No	4,800	5%	20%	18%
Littleton Hospital	Yes	5	Yes	2	No	0	0%	0%	20%
Mary Hitchcock Memorial Hospital	Yes	14	Yes	14	No	7,420	5%	10%	24%
Memorial Hospital	Yes	4	Yes	4	No	0	0%	12%	1%
Monadnock Community Hospital	Yes	2	Yes	6	No	6,000	15%	15%	30%
New London Hospital Assoc.	Yes	2	Yes	3	No	0	4%	0%	13%
Parkland Medical Center	Yes	6	Yes	8	No	1,000	5%	11%	50%
Portsmouth Regional Hospital	Yes	..	Yes	..	No	0	0%	0%	38%
So NH Regional Medical Center	Yes	6	Yes	2	No	2,200	5%	20%	27%
Speare Memorial Hospital	Yes	2	Yes	5	No	0	0%	25%	20%
St. Joseph Hospital	Yes	8	Yes	6	No	2,000	2%	10%	37%
Upper Connecticul Valley Hospital	Yes	4	No	0	No	0	0%	0%	1%
Valley Regional Hospital	Yes	6	Yes	3	Yes	..	0%	1%	5%
Weeks Memorial Hospital	Yes	5	Yes	1	No	0	1%	0%	15%
Wentworth-Douglass Hospital	Yes	5	Yes	32	No	0	0%	1%	24%
Yes/No Counts	26/0		24/2		3/23				
Unweighted Average		5		9		5,110	4%	8%	21%
Median		5		5		0	2%	9%	20%
Minimum		2		0		0	0%	0%	1%
Maximum		14		32		28,000	19%	25%	50%

NOTES:

An '*' indicates that a hospital owns an equity share in an HMO or PPO.

An HMO is a health maintenance organization.

A PPO is a preferred provider organization.

A risk sharing contract is a payment agreement in which a hospital and a managed care organization share in any losses and profits.

A capitated contract is a fixed payment per enrollee that obligates the hospital to provide a range of services for those enrollees.

SOURCE: *AHA Annual Survey of Hospitals* , 1998 and *New Hampshire Hospital Discharge Files*, 1998.

Table 7-1

Regional Comparison of Hospital Financial Performance, 1998

State	Net Revenue/ Discharge	Cost/ Discharge	Profit/ Discharge	Surplus/ Discharge	Operating Margins (%)	Total Margins (%)
New Hampshire	$ 6,372	$ 6,404	$ (32)	$ 478	-0.5	6.9
Rhode Island	6,255	6,509	(254)	343	-4.1	5.0
Vermont	6,777	7,052	(276)	180	-4.1	2.6
Connecticut	6,736	7,055	(319)	337	-4.7	4.0
Maine	7,624	7,507	117	607	1.5	8.4
Massachusetts	6,501	7,833	(1,331)	(15)	-20.5	-0.2
New England Average	6,711	7,060	(349)	322	-5.4	4.5
United States Average	6,509	6,702	(193)	409	-3.0	5.8

NOTES:

Net Revenue = (NPSR / Outpatient-adjusted Discharge) / (casemix index x (0.28 + (0.71 x wage index)))

Cost = (Total Expenses / Outpatient-adjusted Discharge) / (casemix index x (0.28 + (0.71 x wage index)))

Profit = Net Revenue - Cost

Surplus = (Total Revenue - Total Expenses) / Outpatient-adjusted Discharge

Operating Margins = Profit / Net Revenue

Total Margins = Surplus / Total Revenue

SOURCE: *AHA Hospital Statistics,* 2000 and *AHA Annual Survey of Hospitals* , 1998.

Table 7-2

Regional Comparison of Payer-Specific Total Margins, 1998

State	Private Payer	Medicare	Medicaid	Uncompensated Care	All Other	Total
New Hampshire	9.7%	-2.0%	-1.5%	-5.1%	5.9%	6.9%
Vermont	13.0	-6.7	-1.1	-4.2	3.0	4.0
Maine	13.1	-6.3	1.7	-4.2	4.6	8.9
Rhode Island	-0.5	3.8	0.5	-4.0	5.5	5.3
Connecticut	4.6	0.0	-2.3	-3.3	5.1	4.1
Massachusetts	-3.2	0.9	-1.7	-5.1	8.8	-0.3
New England Average	6.1	-1.7	-0.7	-3.0	5.5	4.8
United States Average	5.5	1.0	-0.2	-5.2	4.9	6.1

NOTES:
Total Margins represent the net gains or losses accruing from each payer divided by the payments from each payer.
Uncompensated care payments reflect state and local operating subsidies and include free care and bad debt.
All Other category includes other government health programs and non-patient businesses.

SOURCE: AHA, *Hospital Statistics* , 1998.

Table 7-4

Performance of New Hamshire Hospitals, 1995-1998: Financial

	Net Revenue/ Discharge	Cost/ Discharge	Profit/ Discharge	Surplus/ Discharge	Operating Margins	Total Margins	Days Cash on Hand	Average Annual Net Revenue Growth	Average Annual Cost Growth
Average	5,226	5,253	206	474	4.1	8.2	240	10	10
Median	4,804	5,016	167	423	3.0	7.5	248	10	11
Minimum	2,172	2,103	(2)	(6)	0.1	0.4	81	-12	-14
Maximum	9,304	9,864	528	1425	13.5	17.2	559	57	51

NOTES:
Parkland Medical and Portsmouth Regional are for-profit hospitals and, as such, are not required to submit annual financial statements to the state.
Net Revenue = (GPSR - Free Care - Bad Debt - Contractuals) / (Outpatient-adjusted Discharges x Casemix Index).
Cost = Total Operating Expenses / (Outpatient-adjusted Discharges x Casemix Index).
Profit = (Net Revenue - Operating Expenses) / (Outpatient-adjusted Discharges x Casemix Index).
Surplus = (Total Revenue - Total Expenses) / (Outpatient-adjusted Discharges x Casemix Index).
Operating Margins = Net Operating Revenue / Total Operating Revenue.
Total Margins = Net Total Revenue / Total Revenue.
Net Revenue and Cost Growth = Average annual change in casemix adjusted average net revenue and cost, 1995-1998.

SOURCE:
New Hampshire Hospital Discharge Files, 1998;
Financial indicators calculated by Dr. Kane from information reported on
New Hampshire Hospital Financial Statements, 1998.

Table 7-6

Performance of New Hamshire Hospitals, 1995-1998: Uncompensated Care

	Average Uncomp. Care/Discharge	Share of Uncomp. Care	Share of Self-Pay Discharges	Operating Margins	Total Margins
Average	411	5.3	5.1	4.1	8.2
Median	405	5.5	4.9	3.0	7.5
Minimum	174	3.2	2.8	0.1	0.4
Maximum	632	8.1	9.7	13.5	17.2

NOTES:
As for-profits, Parkland and Portsmouth Regional are not required to submit annual financial statements.
Average Uncomp. Care Spending = (Free Care + Bad Debt) / (Outpatient-adjusted Discharges x Casemix Index).
Share of Uncomp. Care Spending = (Free Care + Bad Debt) / GPSR.
Share of Self Pay Discharges = (Self Pay Discharges / Total Discharges).

SOURCE:
New Hampshire Hospital Discharge Files, 1998;
Financial indicators calculated by Dr. Kane from information reported on
New Hampshire Hospital Financial Statements, 1998.

Hospital Share of Market Inpatient Admissions, 1997

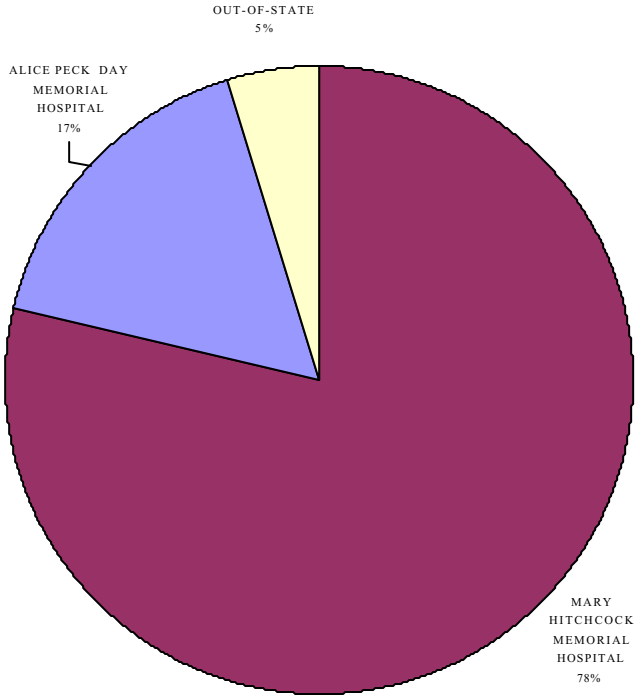
Note: Hospital market areas are based on all ZIP codes from which 3% or more of a hospital's admission originate.

From:

Executive Summary - ***Assessing the Competitiveness of New Hampshire's Health Care Markets: A Focus on Hospitals***

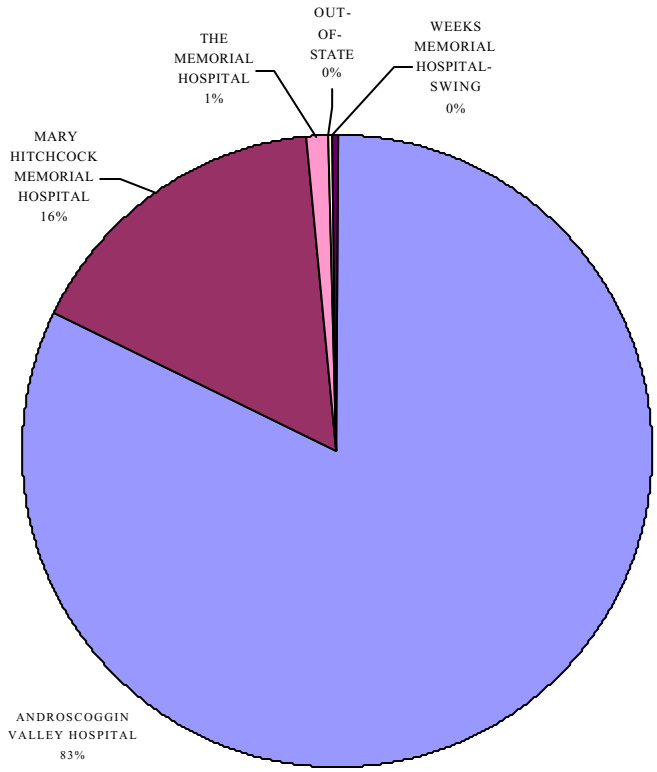
Center for Health Economics Research for the Office of Planning and Research, New Hampshire Department of Health and Human Services; December, 2000

ALICE PECK DAY MEMORIAL HOSPITAL MARKET*



Total = 2,704

ANDROSCOGGIN VALLEY HOSPITAL MARKET*



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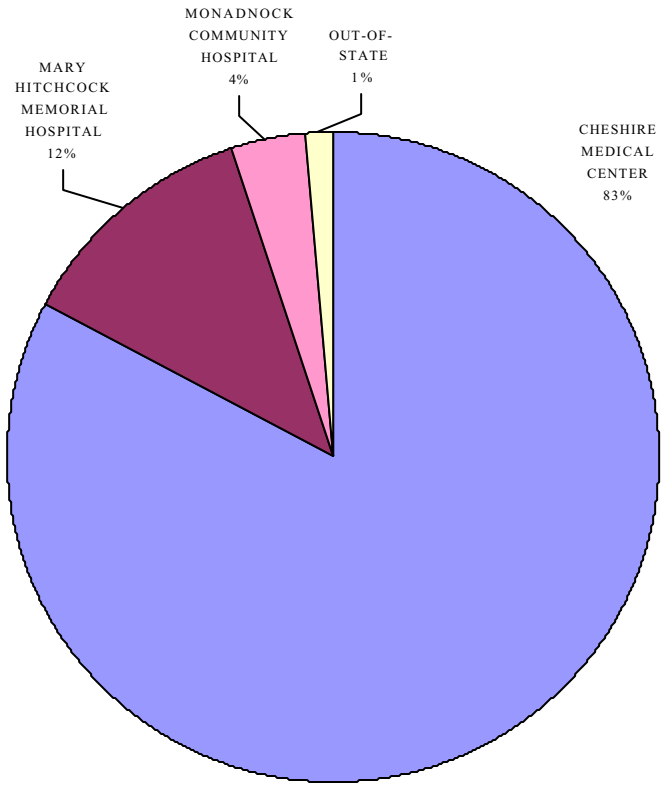

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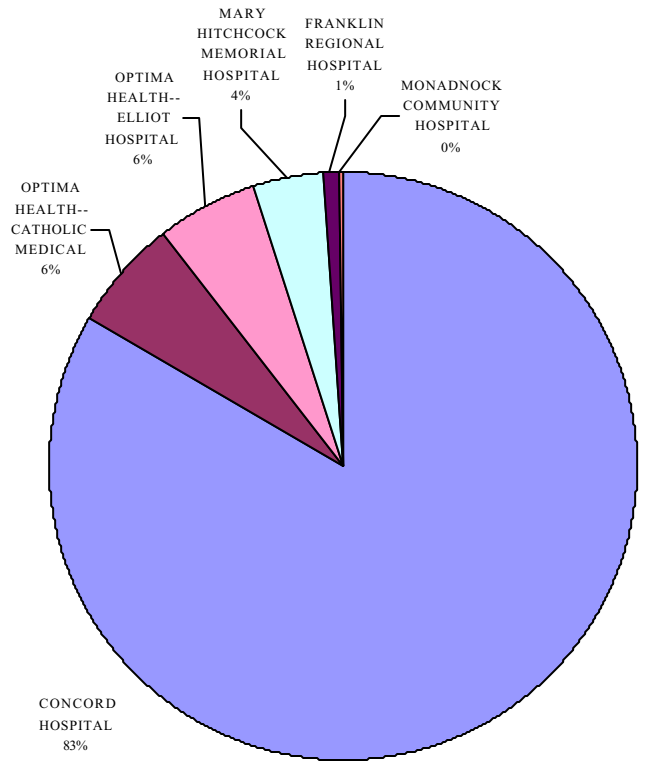
CONCORD HOSPITAL MARKET*



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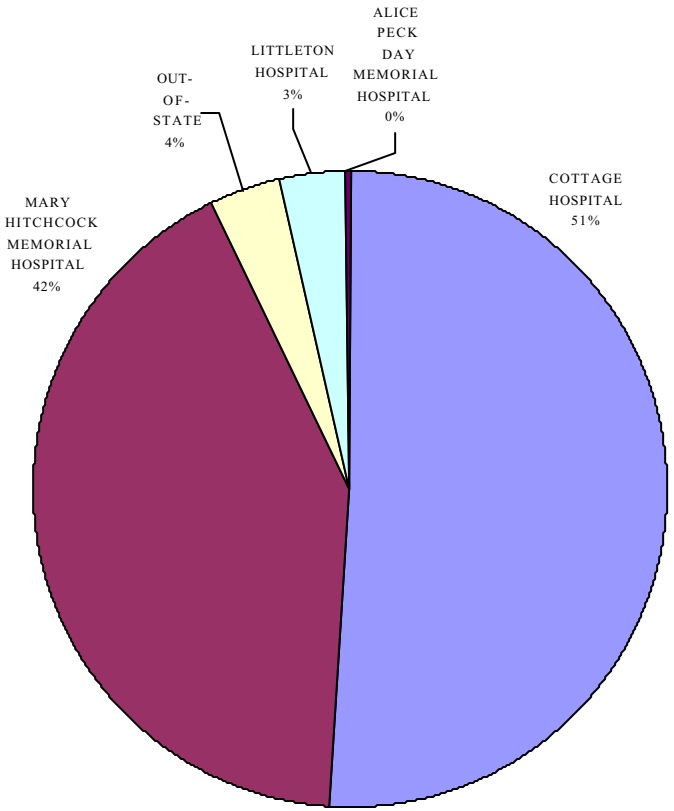

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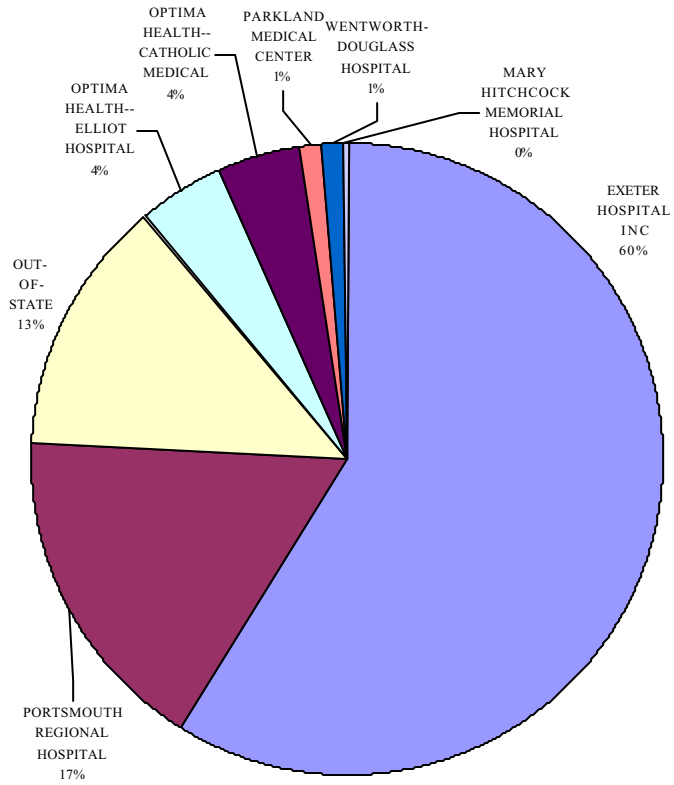

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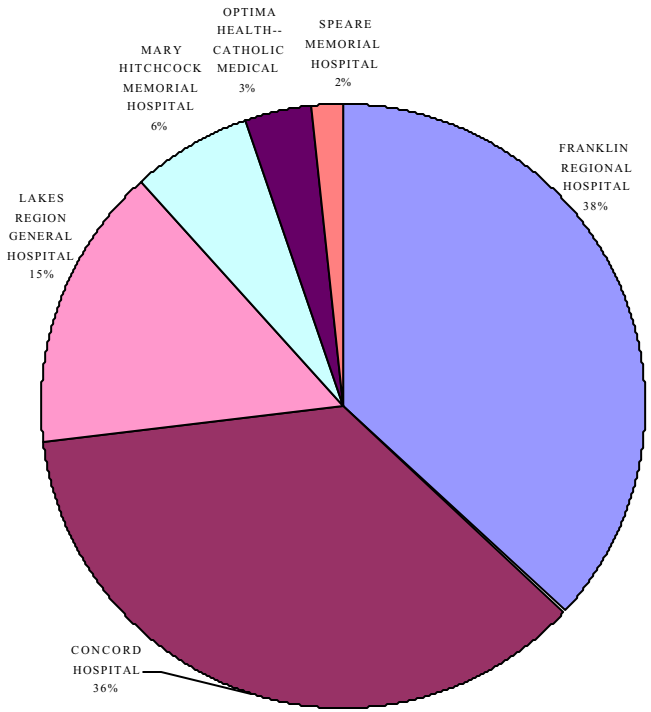
FRANKLIN REGIONAL HOSPITAL MARKET*



Total = 3,692

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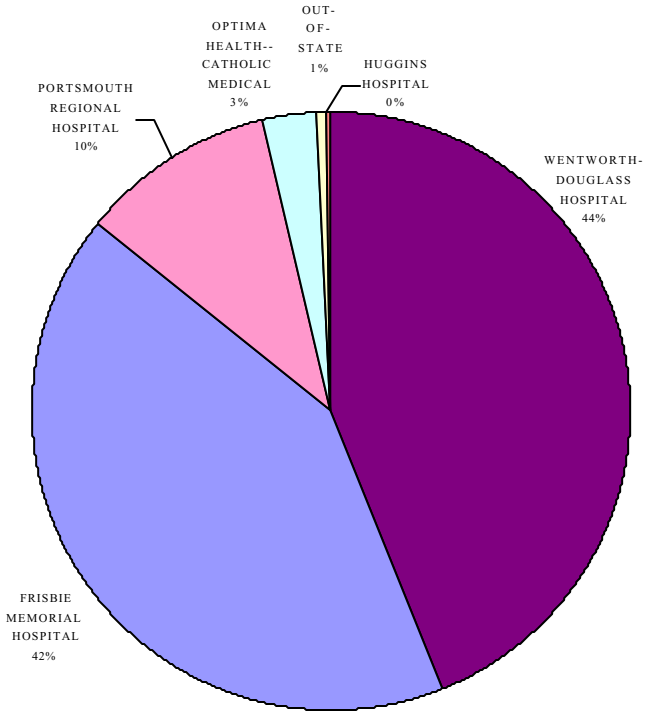

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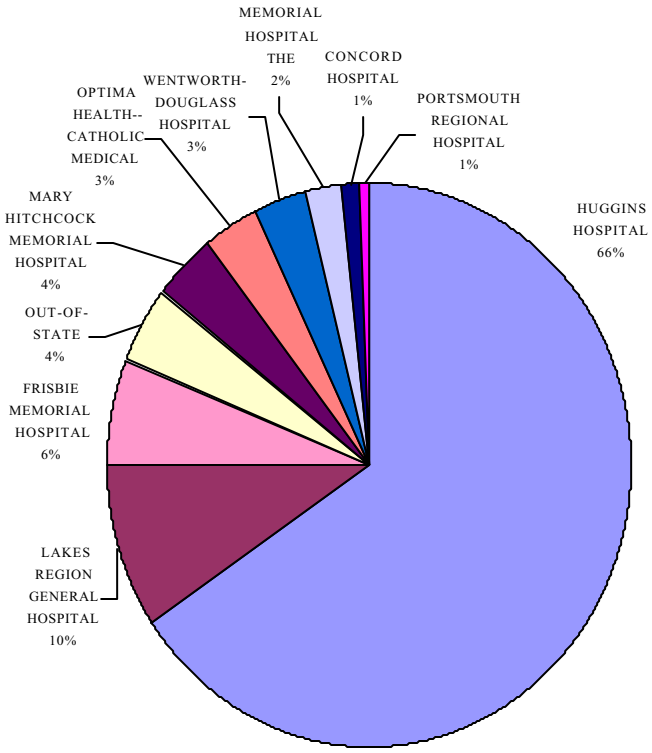
HUGGINS HOSPITAL MARKET*



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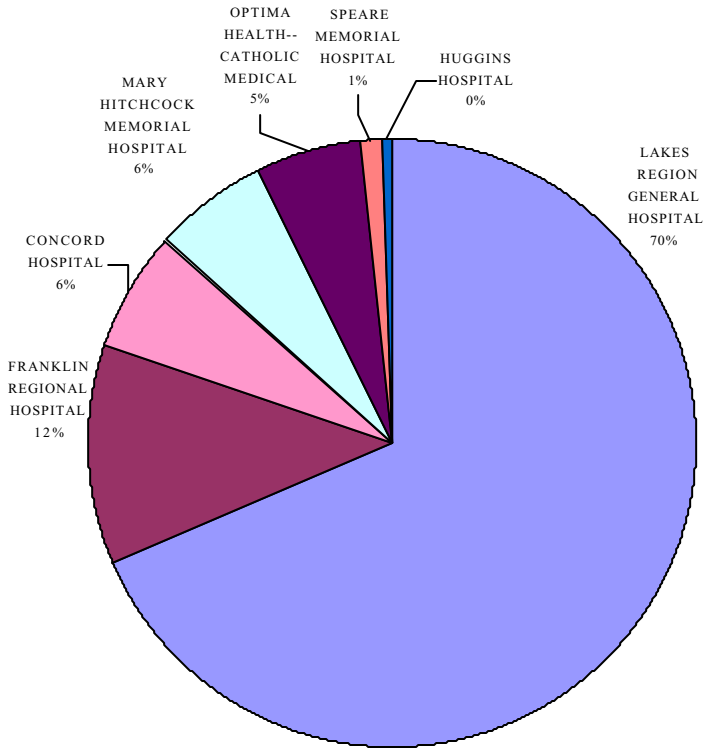

Total = 5,430

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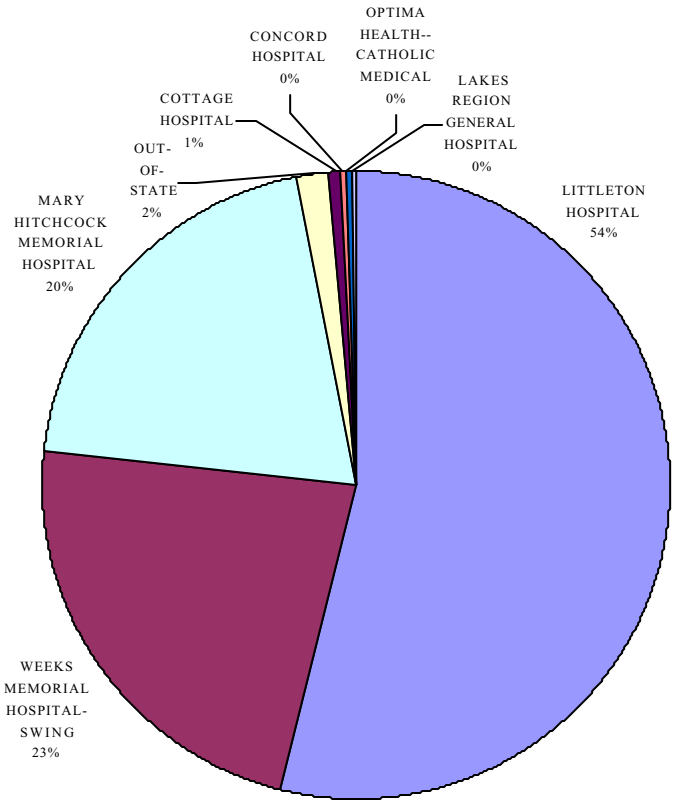

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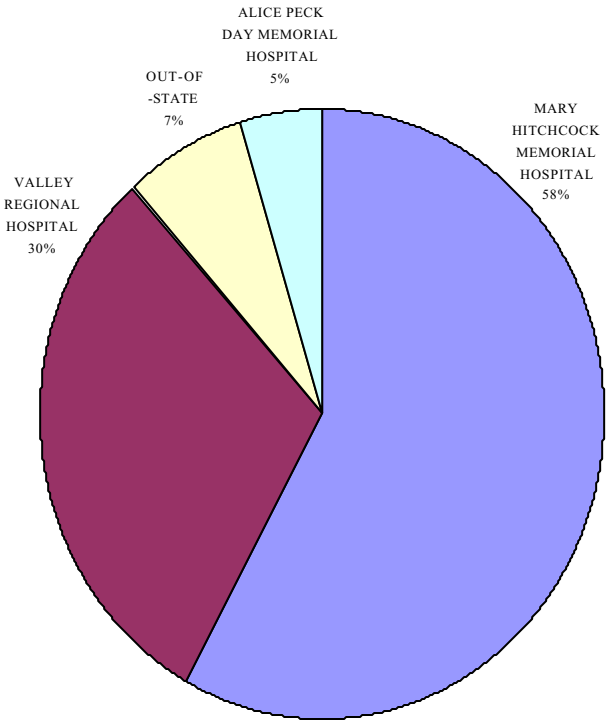
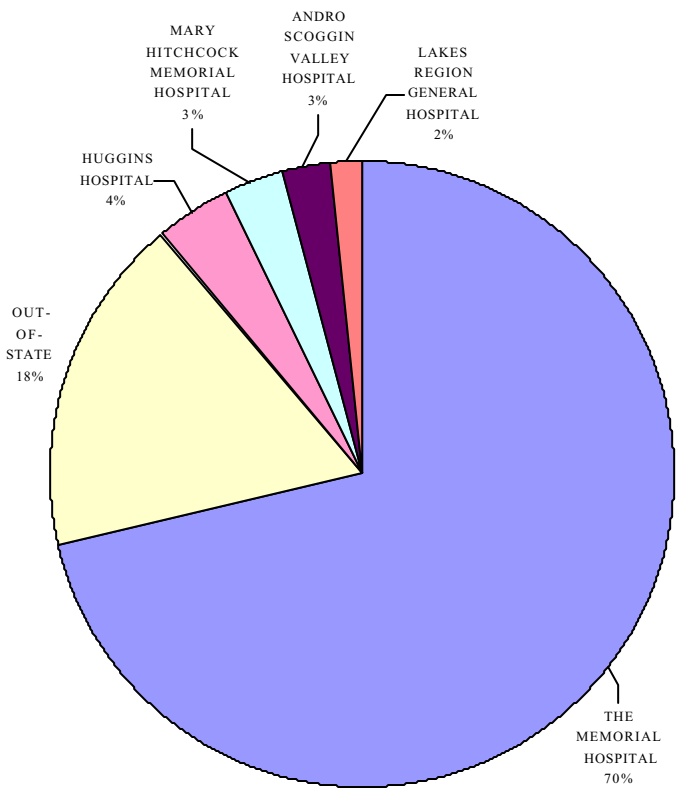


Total = 3,761

THE MEMORIAL HOSPITAL MARKET*



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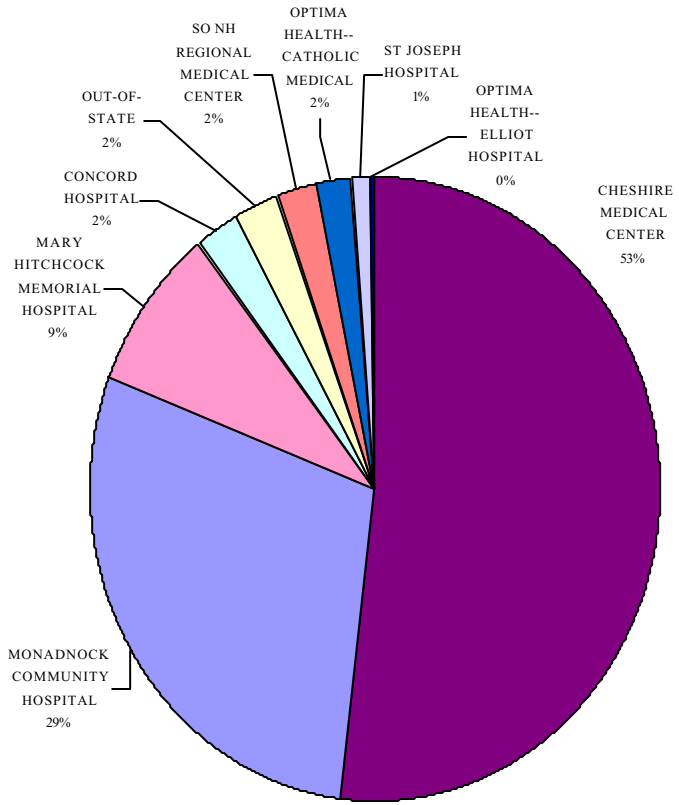

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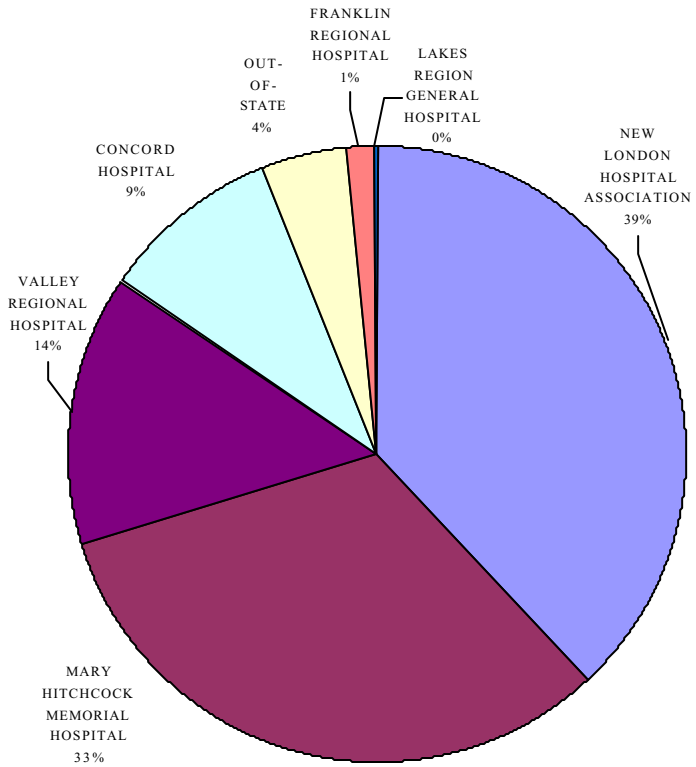
NEW LONDON HOSPITAL ASSOCIATION MARKET*



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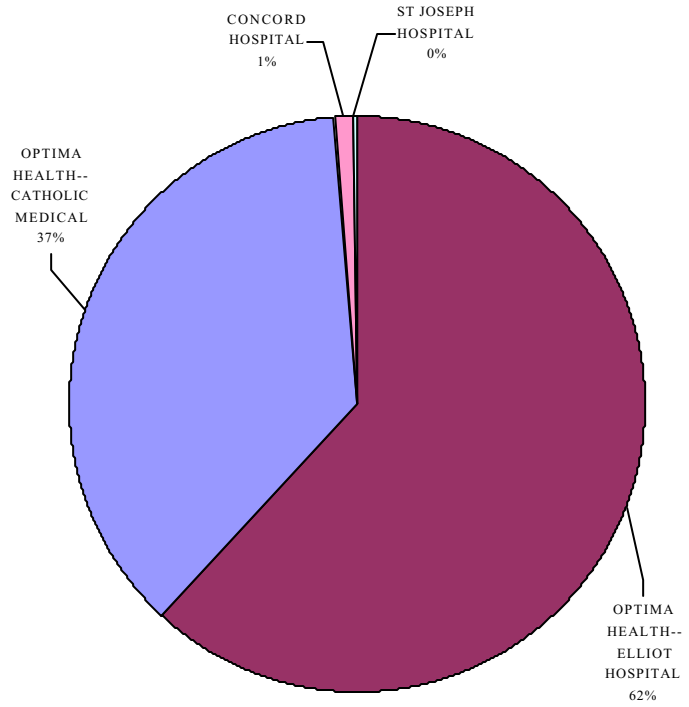
OPTIMA HEALTH--CATHOLIC MEDICAL MARKET*



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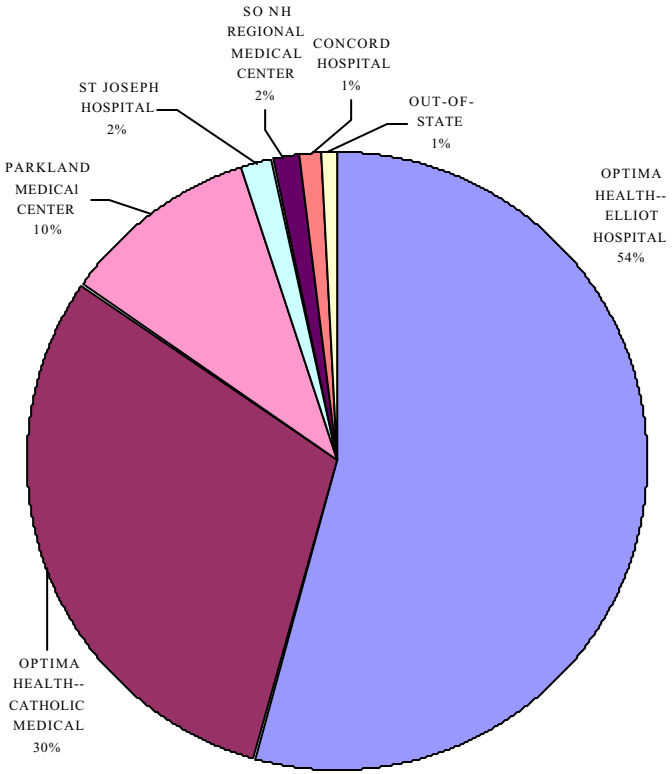
OPTIMA HEALTH--ELLIOT HOSPITAL MARKET*



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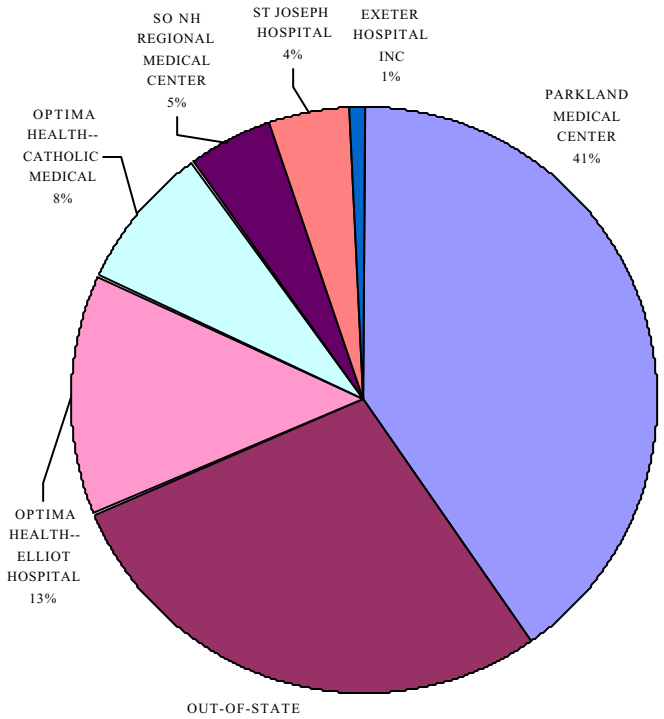

Total = 6,767

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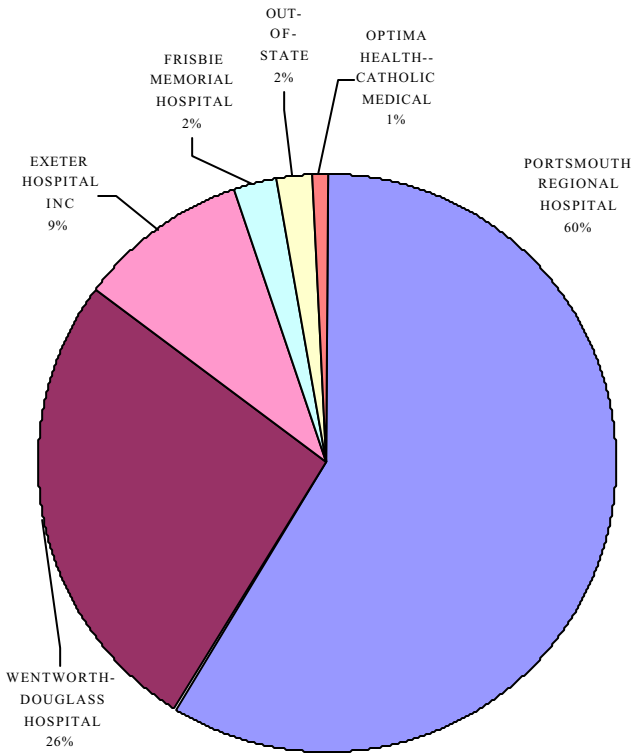

Total = 5,833

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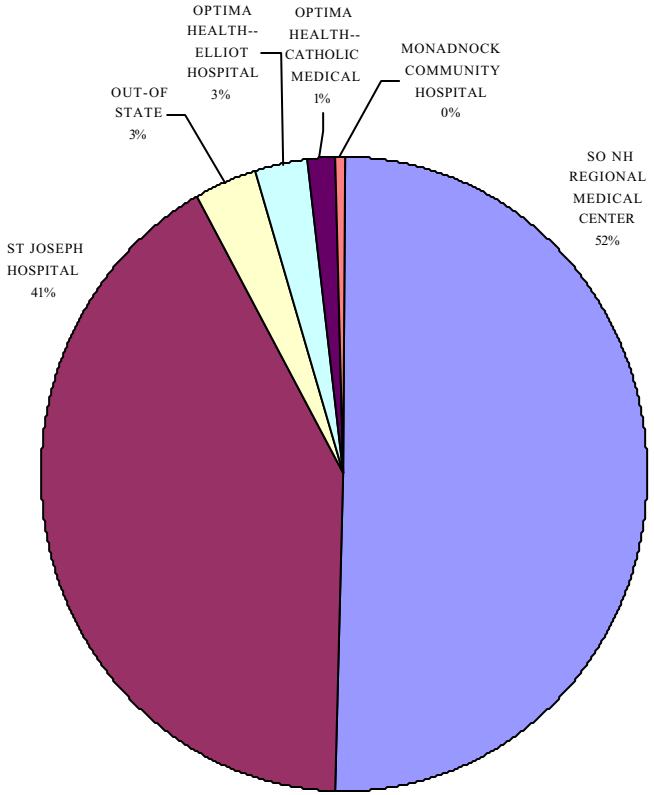
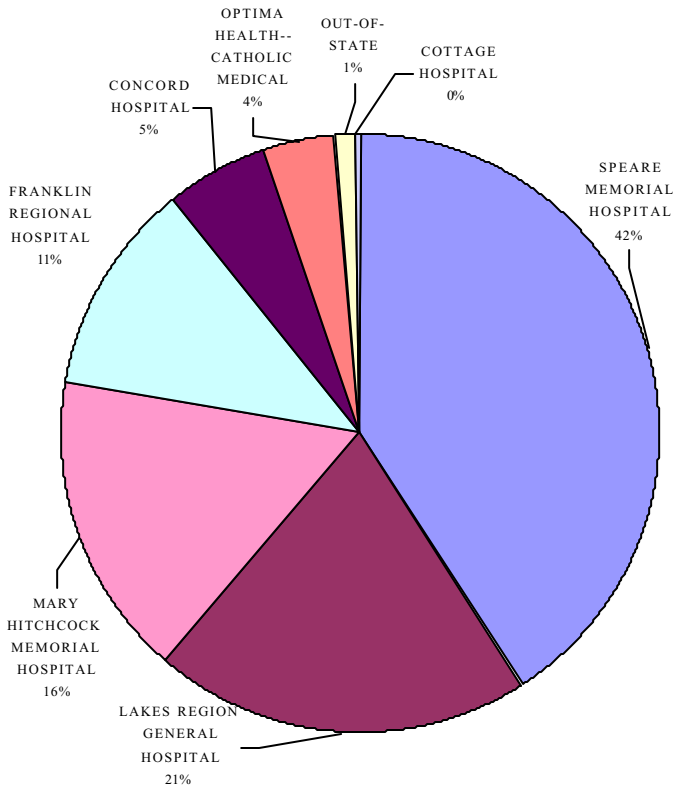


Total = 11,342

SPEARE MEMORIAL HOSPITAL MARKET*



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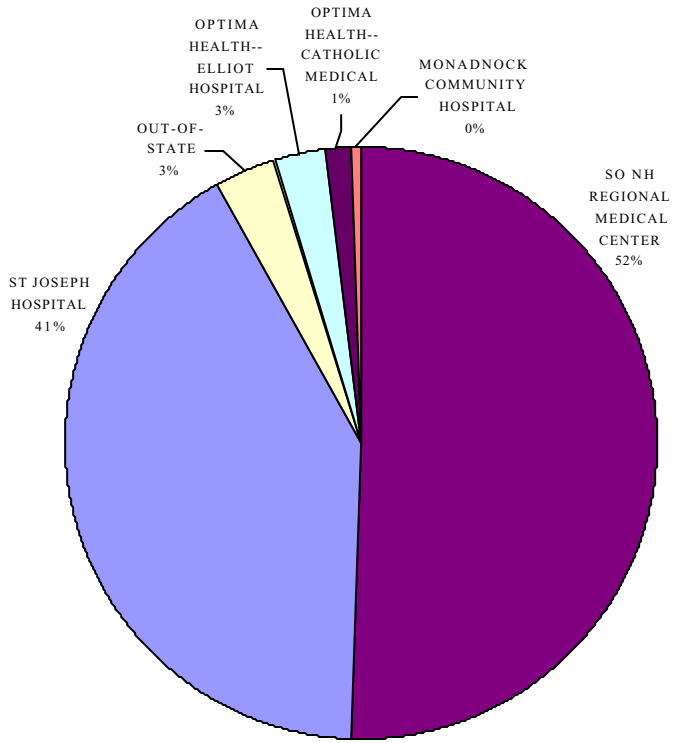

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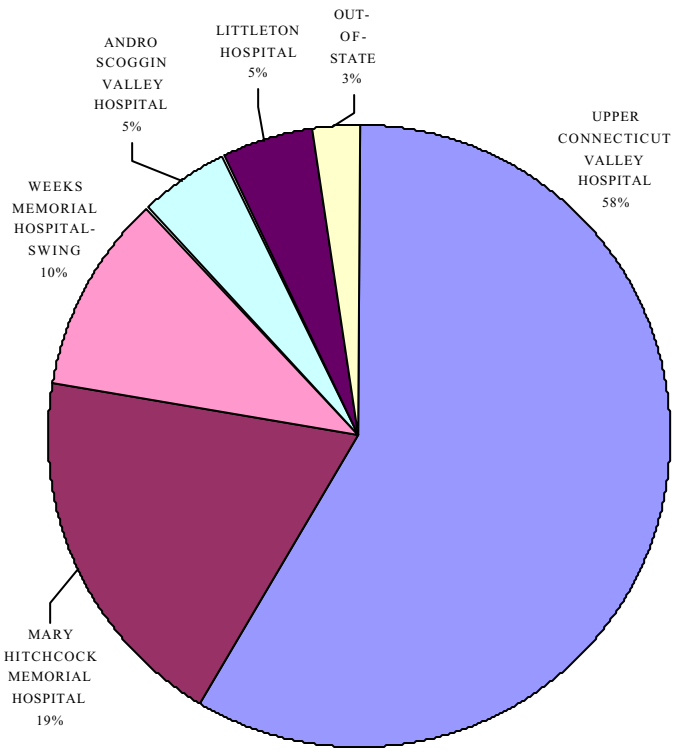

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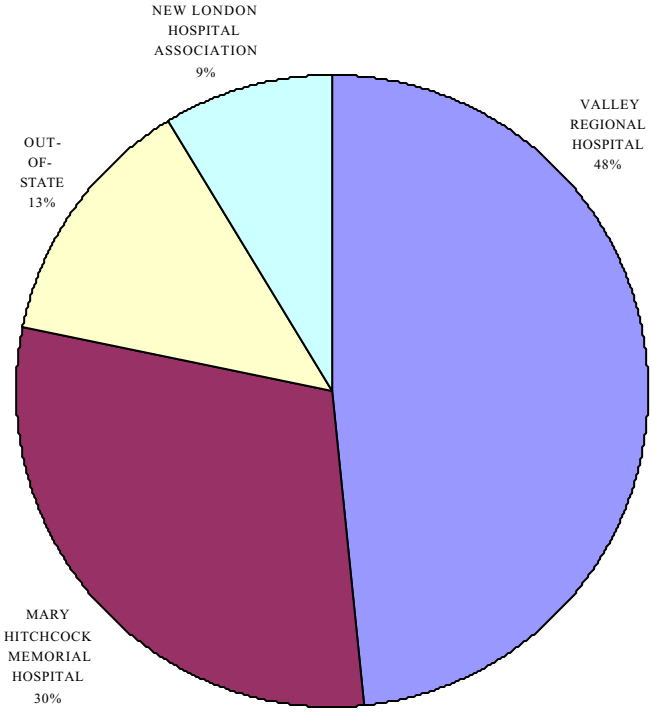

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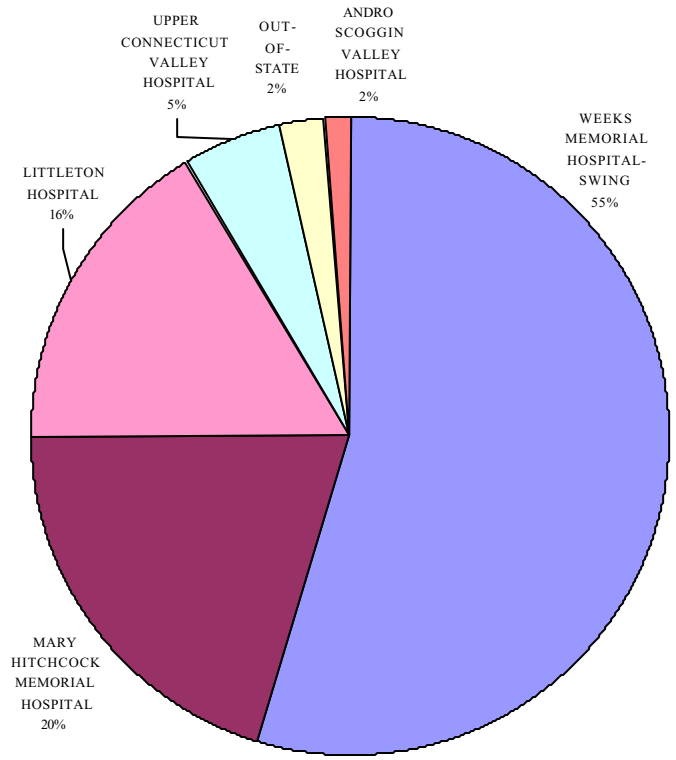

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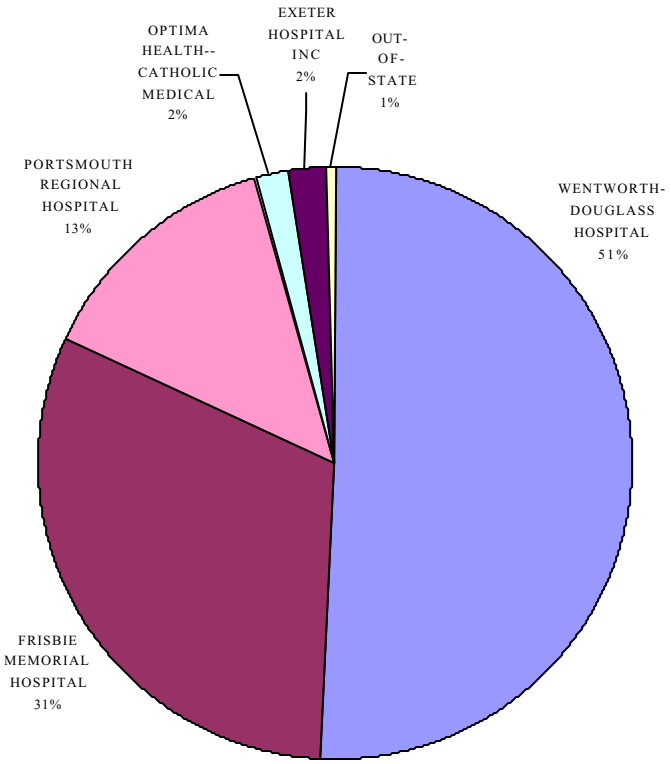

Total = 7,095

The Health of New Hampshire's Community Hospital System

A Financial and Economic Analysis

Section II– Analysis of Health Care Charitable Trusts In the State of New Hampshire: The Hospital Sector




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New Hampshire Department of Health and Human Services
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www.dhhs.state.nh.us

Section II

Analysis of Health Care Charitable Trusts in the State of New Hampshire

The Hospital Sector

Nancy M. Kane, DBA

Harvard School of Public Health

December 2000

Project Funded by Robert Wood Johnson Foundation under the Auspices of

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Done in Cooperation with

New Hampshire Department of Health and Human Services

New Hampshire Department of Insurance

New Hampshire Office of the Attorney General

Spitz Consulting Group, LLC

Contents

Introduction

In March 1999, a financial analysis of the health care charitable trusts of New Hampshire was undertaken to develop an understanding of the general financial condition of nonprofit healthcare organizations in the state[1]. In addition, the original charge was to identify, through publicly available and existing information sources, the quantifiable community benefits provided by these organizations. The information developed in this analysis had been intended for use as background to policy discussions on community benefits with New Hampshire Health District Councils[2] and other parties interested in the design and implementation of new legislation "to ensure that health care charitable trusts provide the communities they serve with benefits in keeping with the charitable purposes for which the trusts were established..."[3] The New Hampshire State Legislature passed a "charitable activities" bill roughly five months subsequent to the undertaking of this project; that law reinforces the need for the state to provide accurate factual information to communities about their health care charities as they become involved in the development of community benefit plans that are responsive to the true needs of the community. However, the legislation adopted a broad definition of community benefit for all health care charitable trusts that goes beyond the three measures analyzed here.

This report focuses on the 24 nonprofit hospitals in New Hampshire, due to the fact that they are the largest health care charitable organizations in the state, and that there is more publicly available financial information about them than about other health care charities in the state. We have also identified the size and nature of many of the organizations affiliated with hospital charitable organizations, such as parent holding companies, foundations, physician management organizations, and home care agencies.

The first report released in this series focused on the financial analysis of community health centers in New Hampshire, of which there are roughly 10 freestanding entities. A third major sector of health care in New Hampshire, the health insurance sector, has become dominated by noncharitable organizations; the sector is also in a state of flux given the conversion of the largest health plan (Blue Cross Blue Shield of New Hampshire) and the liquidation of another (Tufts

[1] Results of this analysis were also used in an economic analysis of the NH health care market.
[2] Seven District Councils were established in 1996 to develop the State Health Plan; they continue to meet on a regular basis to provide a "community voice" in the development and evaluation of state health policy.
[3] SB0069: An Act Relative to health care charitable trusts and community benefits, approved July 16, 1999, effective January 1, 2000, for trusts with assets of $1 million or more, and January 1, 2001 for trusts with assets greater than $100,000.

New England). A third report - the financial status of health plans – will also be released in order to provide information on the private health insurance context within which hospitals and plans operate in New Hampshire.

Our mandate was to review and analyze the audited financial statements and available IRS Form 990 reports of charitable hospitals and their affiliates, and to make preliminary recommendations for benchmarks to monitor their charitable activities. [4] Our benchmark recommendations must rely upon data that can be routinely collected from existing data sources.

Overview of Benchmarks

We divided our analysis into two types of benchmarks: those associated with financial position, and those associated with the level of quantifiable community benefit provided.[5]

Financial Benchmarks

Financial benchmarks include the traditional measures of profitability, liquidity, solvency, and cash flow. Each of these areas of analysis is defined briefly below; additional information about the ratios or the nature of financial analysis can be obtained by consulting health care financial texts (Gibson 1992; Cleverley 1992), and by reviewing the glossary of The Almanac (CHIPS, 1999), from which our national and regional comparative ratios are drawn. The financial benchmarks are derived from audited financial statements except where noted. For these ratios, it can be helpful to understand how a hospital's balance sheet and income statement elements are generally portrayed (**see APPENDIX A**).

[4] Copies of the IRS 990 filings for 650,000 charitable trusts in the US can now be viewed online at: www.guidestar.org. At this point, however, the financial data available is not consistent across organizations and only includes 1998.

[5] Two of the indicators chosen under "quantifiable community benefit" are not allowable under SB 69; the broad definition of community benefit adopted under the statute will allow for quantifiable community benefits that might not show up in audited financials.

	Purpose	Calculation
Profitability:		
Total Margin	Measures the organization's ability to cover expenses with revenues from all sources	Ratio of (Operating Income and Nonoperating Revenues)/Total Revenues
Operating Margin	Measures the organization's ability to cover operating expenses with operating revenues	Ratio of Operating Income/Total Operating Revenue
Non-PPS Payment/Cost	Measures the relationship between payment and costs of all payment sources other than Medicare PPS[6]	Ratio of (Total Operating Revenue minus PPS Payments) / (Total Operating Cost minus PPS Costs)
Markup Ratio	Measures the relationship between hospital-set charges and hospital operating costs; generally only self-pay and indemnity payers pay hospital charges	Ratio of (Gross Patient Service Charges Plus Other Operating Revenue) / Total Operating Expense
Deductible Ratio	Measures the relationship between hospital's contractual discounts negotiated with (private payers) or taken by payers (Medicare and Medicaid) and hospital charges	Ratio of Contractual Adjustments/Gross Patient Service Revenue
Nonoperating Revenue Contribution	Measures the contribution of nonoperating revenues (activities that are peripheral to a hospital's central mission) to total surplus or deficit	Ratio of Nonoperating Revenues (includes unrestricted donations, investment income, realized gains (losses) on investments and peripheral activities)/Excess Revenue over Expense

[6] Medicare's Prospective Payment System includes only inpatient-related operating and capital costs and excludes Medicare payments for outpatient costs, which have not been part of PPS through 1998.

Realized Gains to Net Income	Measures the contribution of realized gains (a subset of nonoperating revenues) to total surplus or deficit	Ratio of realized gains (losses)/Excess Revenue over Expense
Liquidity:		
Current Ratio	Measures the extent to which current assets are available to meet current liabilities	Current Assets/Current Liabilities
Days in Accounts Receivables	Measures how quickly revenues are collected from patients/payers	Patient Accounts Receivable/(Net Patient Service Revenue / 365)
Average Pay Period	Measures how quickly employees and outside vendors are paid by the hospital	(Accounts Payable and Accrued Expenses)/ (Average Daily Cash Operating Expenses)[7]
Days Cash on Hand	Measures how many days the hospital could continue to operate if no additional cash were collected	(Cash plus short-term investments plus noncurrent investments classified as Board Designated)/(Average Daily Cash Operating Expenses)
Solvency:		
Equity Financing Ratio	Measures the percentage of the hospital's capital structure that is equity (as opposed to debt, which must be repaid)	Unrestricted Net Assets/Total Assets
Cash Flow to Total Debt	Measures the ability of the hospital to pay off all debt with cash generated by operating and nonoperating activities	(Total Surplus (Deficit) plus Depreciation and Amortization Expense)/Total Liabilities
Average Age of Plant	Measures the relative age of fixed assets	Accumulated Depreciation/ Depreciation Expense

Cash flow analysis uses the hospital's cash flow statement to identify, over a period of a year or more, the hospital's sources and uses of cash after all operating expenses have been met. The cash flows in our analysis are aggregated over all hospitals for the years 1993 through 1998 to show total sources and uses of cash statewide. 1999 is aggregated separately and analyzed for changes from the 1993-1998 period.

[7] (Operating Expenses Less Depreciation Expense Less Bad Debt Expense)/365

There are three basic sources of cash: operating activities (cash profits), investing activities – the selling of assets, and financing activities (obtaining outside capital, including long-term debt, donations, and transfers of cash into the hospital from related organizations). The "healthiest" way to generate cash is through operating activities. A hospital that has to resort to selling off its assets to any substantial degree is not in a sustainable mode. Finally, while a limited amount of borrowing, particularly for working capital or fixed assets, is appropriate, over-reliance on outside sources of capital can become problematic, particularly if the capital has to be repaid or, in the case of transfers from related entities, there is a limit to the amount of cash available.

Similarly, there are three basic ways to use cash: operating activities (cash deficits from operations or nonoperating activities), investing activities (acquiring buildings, equipment, marketable securities, other businesses), and financing activities (paying off debts, transferring cash to related entities). The healthiest use of cash is generally investing activities – adding long-term assets that will produce future economic benefits for the hospital. As long as investing needs are met (particularly fixed asset needs), then it is a healthy sign if financing activities such as the repaying of debt is a use of cash. It is unhealthy for operating activities, particularly operating and nonoperating deficits, to be a use of cash for a period of several years. Generally, organizations cannot survive long if operating activities do not generate cash. The table below provides a guide, at a gross level, of the healthy vs. unhealthy pattern of sources and uses of cash.

	Source of Cash	**Use of Cash**
Operating Activities (operating income, nonoperating revenues, and working capital)	Healthy – best source of cash, especially if from operating income	Not Healthy over Sustained Period
Investing Activities (investments in property, plant, and equipment, acquisitions, marketable securities, affiliates)	Not Healthy	Healthy
Financing Activities (borrowing, capital transfers from related entities, capital donations)	Healthy in Short Term as a way to finance fixed assets, within ability to service debt Unhealthy if needed to cover operating deficits or borrowing exceeds ability to repay	Healthy if organization can afford to repay debt and still meet investing needs Unhealthy if all available cash flow is going to debt repayment or entity transfers at the expense of needed fixed asset investments

Community Benefit Benchmarks

Quantifiable community benefit benchmarks are less well established than financial performance benchmarks, and even those that can be quantified are less standardized than the traditional elements found on balance sheets, income statements, and statements of cash flow. Several states have developed community benefit reporting formats with detailed instructions on how to quantify and report the various types of community benefits that might be important to a particular community (Noble, Hyams and Kane, 1999). New Hampshire also has a formal community benefit reporting format. [8]

Our community benefits analysis was more exploratory than is the financial analysis. It sought to identify the elements of community benefits that are currently reported and publicly available, and to relate those elements to various denominators used to calibrate the relative adequacy of those benefits (e.g., the value of tax benefits and the level of gross patient revenues). The intent was to identify potential benchmarks and show how hospitals measure up against those benchmarks with historical data, much of which is based on estimates. However, the state decided (in SB 69) to define and collect a broader array of measures of community benefits. Two of the elements examined – bad debt and Medicaid shortfalls – may not be counted as community benefits. They are presented here as examples.

We were able to directly obtain only one measure of community benefit across all hospitals – the provision of free care. Values for bad debt (in charges) are also directly available. However, the new Community Benefits statute is clear that "charity care" should not include bad debts, which are amounts the hospital initially classifies as revenues owed to them, and which it is subsequently unable to collect (generally after multiple efforts to collect have failed). We do not intend to imply that this distinction is not appropriate. We acknowledge that it is likely, based on the literature on this topic, that at least some of the bad debts shown on historical financial statements are likely to have been considered free care if certain conditions had been present (i.e., a free care policy was publicly posted and patients were aware of its existence; or a hospital was willing to devote the resources to actively identify reluctant recipients of charity and help them fill out the necessary forms for eligibility, which could also require the availability of translation

[8] The first community benefit plan filings, together with the results of the (statutorily required) community needs assessments, were received in the Office of the Attorney General, Charitable Trusts Unit, in the fall of 2000. The list of filings received to date and information on how to obtain copies is available on the Unit's website: http://webster.state.nh.us/nhdoj/CHARITABLE/char.html.

services). In recognition of the likelihood that some bad debt may be free care, we considered the impact on our benchmarks if 50% of bad debts were considered to be charitable, as one benchmark possibility. If free care designations receive heightened scrutiny in the future, we think it is likely that some patients who would historically have been classified as bad debtors will instead be classified as free care recipients. Thus, our historical benchmark analysis adjusts for that possibility.

From our early presentations to hospitals, some hospital representatives felt that Medicaid shortfalls (the shortfall between Medicaid payment and Medicaid costs) should be considered as part of the community benefits hospitals provide. Only a handful of hospitals quantified the Medicaid shortfall in the footnotes to their audited financial statements. To at least begin the policy debate on the role of Medicaid shortfalls, we undertook an estimation of Medicaid shortfalls for each hospital for 1998 only, based on a study done by the New Hampshire Department of Health and Human Services, Office of Planning and Research. If Medicaid shortfalls are to be considered quantifiable community benefits in the future, it is recommended that the state develop a standardized method for calculating and reporting this value.

Another element of community benefits that we considered is the provision of what is considered in the literature to be "essential community services" that nearly always incur operating deficits. These services include neonatal intensive care units, trauma services, burn units, and HIV/AIDS services. Although we do not have the information to quantify losses incurred on such services, we did identify which hospitals had them.

The value of tax benefits is based on the following measures:

Property Tax	Equalized Tax Rate * Hospital Building and Land Assessments	For missing values, property tax was estimated using the equation: Operating Expense * .010 – 21 (based on regression analysis)
Business Enterprise Tax	Interest, payroll and fringe benefit expense * .0025	Included interest, payroll and fringe expenses as reported in audited financial statements; missing values were derived from payroll and fringe amounts reported in AHA guide, or, if fringes not available there, were estimated by multiplying payroll times 22%, the average fringe/payroll ratio for the period 1993 to 1998.
Business Profit Tax	Net Income * .07	For values below 0, value = 0
Federal Income Tax	(Net Income – Property Tax – Business Enterprise Tax – Business Profit Tax) * .35	For values below 0, value = 0.

Our charitable benchmarks are summarized in the table below.

Benchmark	**Purpose**	**Calculation**
Free Care/Gross Patient Service Revenue	Quantifies the percentage of total services that are provided to charity patients	Free Care (valued at charges)/Gross Patient Service Revenue (Both sides of equation valued at charges to measure "apples to apples")
Bad Debt/Gross Patient Service Revenue	Quantifies the percentage of total services that are provided to people who are charged but do not pay their bill	Bad Debt (valued at charges)/ Gross Patient Service Revenue
Free Care at Cost/Value of Tax Exemptions	Compares the level of free care, valued at average cost, to the benefits of tax exemption	(Free Care Valued at Charges/Markup Ratio)/Total Tax Value
50% of Bad Debt At Cost/Value of Tax Exemptions	Compares how 50% of bad debt relates to the benefits of tax exemption	((.5* Bad Debt Valued at Charges)/Markup Ratio)/Total Tax Value
Medicaid Shortfall/Value of Tax Exemption	Compares estimated Medicaid Shortfall, to the value of Tax Exemption	Estimated Medicaid Shortfall/Total Tax Value
Other Quantifiable Benefits	Identifies existence of essential community services that might be classified as community benefits	No quantification made

Findings

Financial Benchmarks

Profitability

Figure 1 shows the distribution of values for **total margin** for the 24 New Hampshire hospitals through 1998, and for 22 hospitals for 1999. For comparative purposes, the median (50th percentile) values for the Northeast Region (NE) and for the nation (NAT) are also provided. The Northeast Region includes hospitals in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, and Pennsylvania. National and regional medians for 1998 will not be available until December 2000.

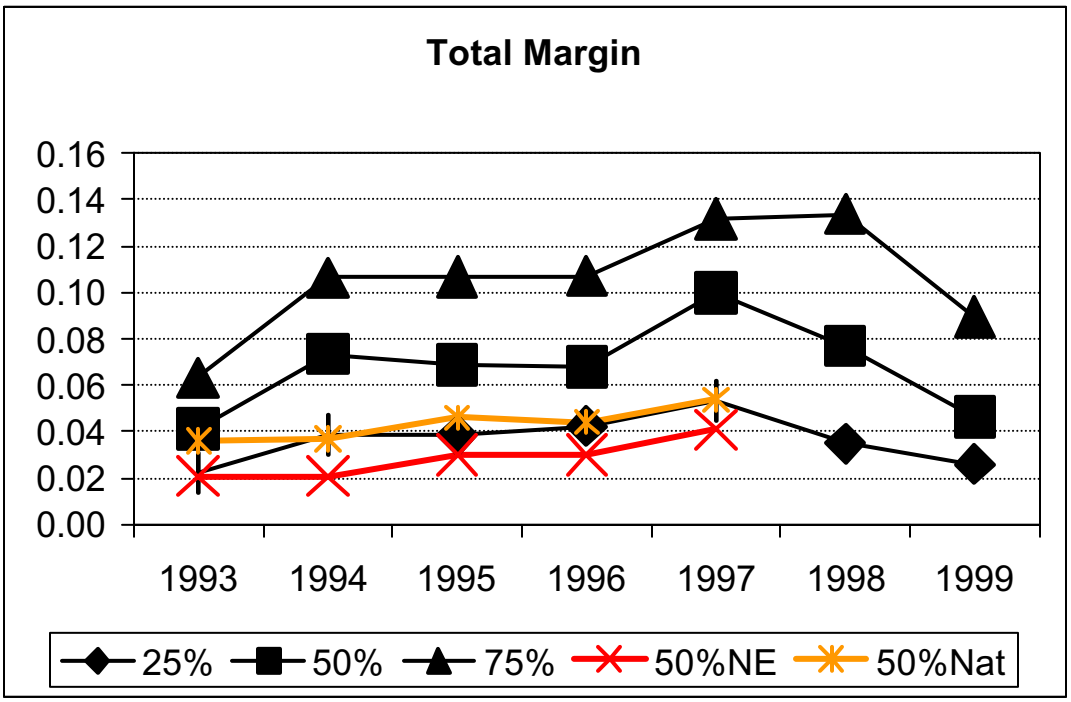


Figure 1

It is apparent from Figure 1 that between 1993 – 1997, New Hampshire hospitals outperform their regional and national counterparts on total margins: the national median is roughly at the level of the bottom quartile of New Hampshire hospitals, while the regional median falls below the New Hampshire bottom quartile. In other words, 50% of hospitals nationally had total margins at or below 3.6% in 1993, rising up to 5.4% in 1997. In New Hampshire, the lowest performing 25%

of hospitals had total margins at or below 2.3% in 1993, rising to 5.3 % in 1997. New Hampshire medians went from 4% in 1993 to a peak of 10% in 1997, falling back to 7.7% in 1998. In 1999, the total margin falls back to the 1993 levels, with a median of 4.4%.

Figure 2 represents the distribution of values for operating margins, which are a good indication of how well hospitals are doing in terms of keeping their patient care costs within the limits of their third party reimbursements. Relative to national and regional medians, New Hampshire hospitals again outperform. Only in 1993 did the median for New Hampshire hospitals fall below the national median (1% vs. 1.8% respectively); in all other years, the New Hampshire median stayed at or above the national median, with operating profit margins ranging from 3 – 5%, until 1998. Regional medians were at or below the bottom quartile of New Hampshire hospitals between 1994 and 1997. In 1998, median operating margins fell to 2% (no comparative data available), and in 1999, they dropped to 1%. The 1999 values approximate the 1993 values for the 50th and 75th percentiles, but are well below 1993 levels (25th percentile of -.03, compared to 1993 of -.01) for the bottom quartile of hospitals.

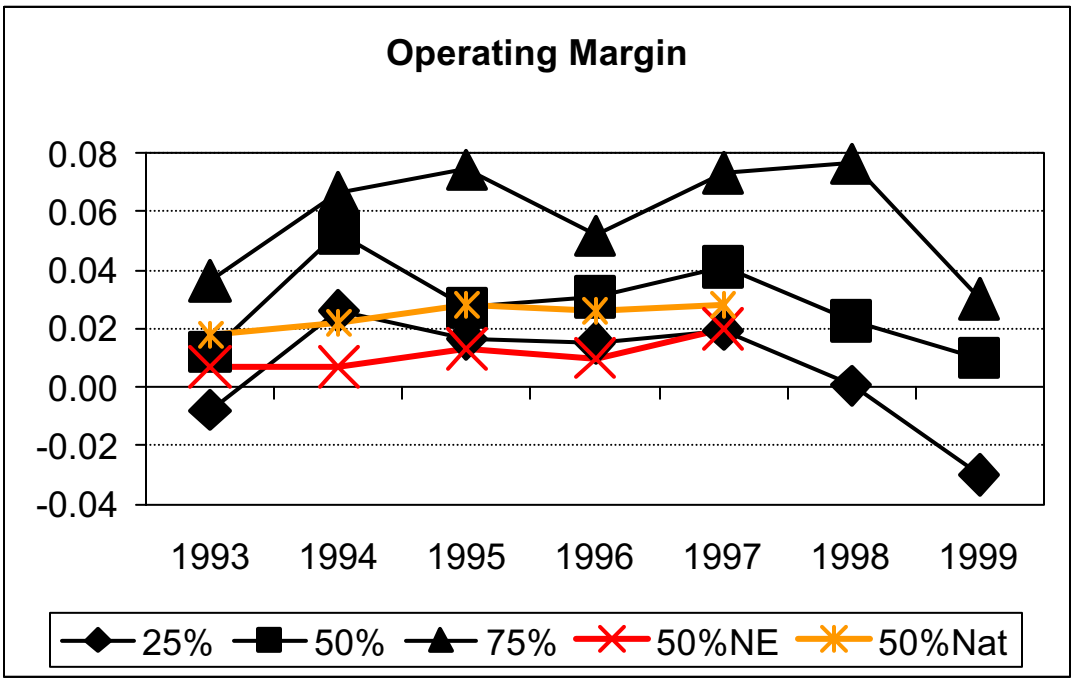


Figure 2

Figure 3 is the ratio of Medicare PPS Payment to PPS cost for the period 1994 – 1997 (the period for which the Medicare Cost Report data were available). This figure indicates that, for 75% of New Hampshire hospitals, the Medicare PPS payment to cost ratio was at or below 1 for the period 1994 – 1997. For the bottom quartile of hospitals, the PPS payment to cost ratio was at or below 80%. In other words, most New Hampshire hospitals have been losing money on Medicare inpatient care throughout the period of our analysis. As of 1997, the aggregate loss on the Medicare PPS was roughly $11 million.[9] In 1998, given the changes in the Medicare PPS made by the Balanced Budget Act of 1997, we estimated that the aggregate loss doubled to roughly $20 million (depending on how costs behave).

[9] PPS losses estimated based on the following formula (numbers in parens refer to field number on Medicare Minimum Data Set):
DRG Payment (f470) plus Outlier Payments (f471) plus Indirect Medical Education Adjustment (f477) plus Disproportionate Share Adjustment (f479) plus ESRD Payments (f480) = PPS Payments
Total Medicare Inpatient Operating Cost (f458) minus Capital Pass Through Costs (f376-f349-f350) minus Direct Medical Education Pass-through Costs (f440-f413-f414) = PPS Costs
Payments minus Costs = PPS Gains (Losses).

PPS Payment to Cost Ratios
1994 - 1997

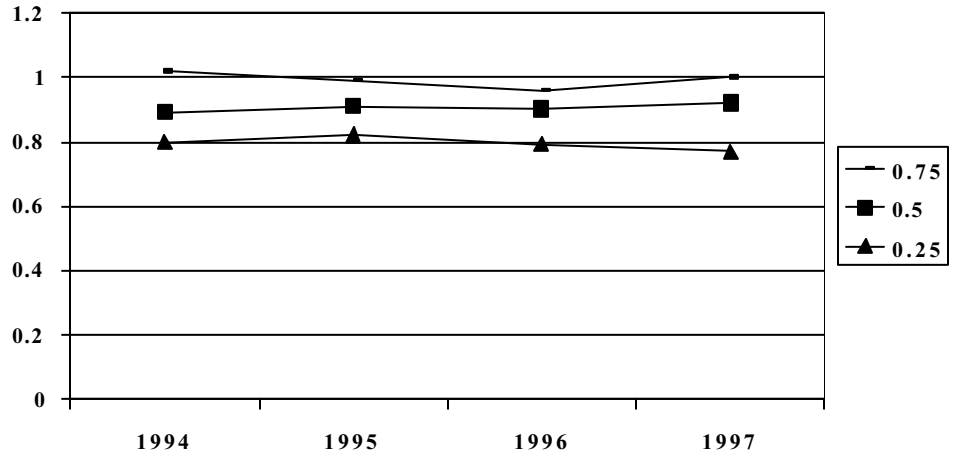


Figure 3

Non-PPS Payment to Cost Ratios
1994 - 1997

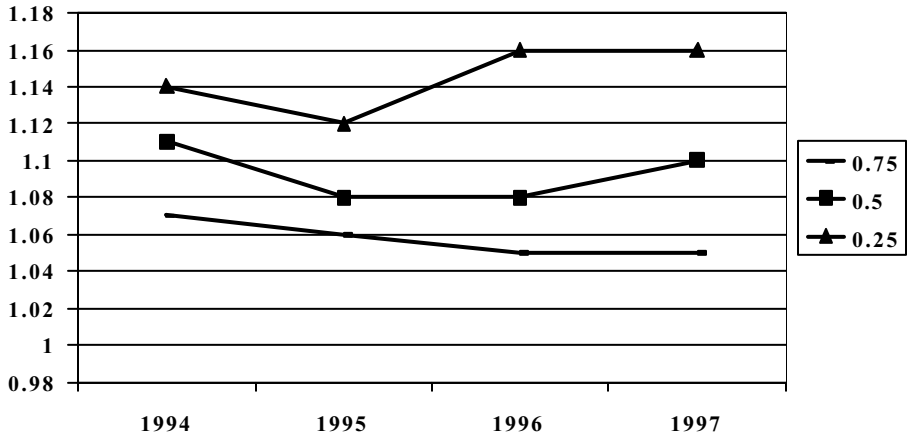


Figure 4

Given the positive operating margins of most New Hampshire hospitals, they are obviously making money on the other payers, which Figure 4 shows. The ratio of payments to costs for non-PPS payers (which includes outpatient care for Medicare patients) is well above 1. Thus in 1997, for 50% of hospitals, non-PPS payers pay above 110% of cost; for only 25% of New Hampshire hospitals do non-PPS payers pay at or below 105% of cost.

Figure 5 shows the markup of hospital charges above costs. New Hampshire markups are generally below regional and national markups. The median markups of hospitals' charges over costs in New Hampshire are roughly 1 – 4% lower than their regional and national counterparts, and the gap is narrowing over time. This does not say anything about absolute price levels; relative cost information is necessary for that. The distribution of markup ratios does not change significantly in 1999 over 1998.

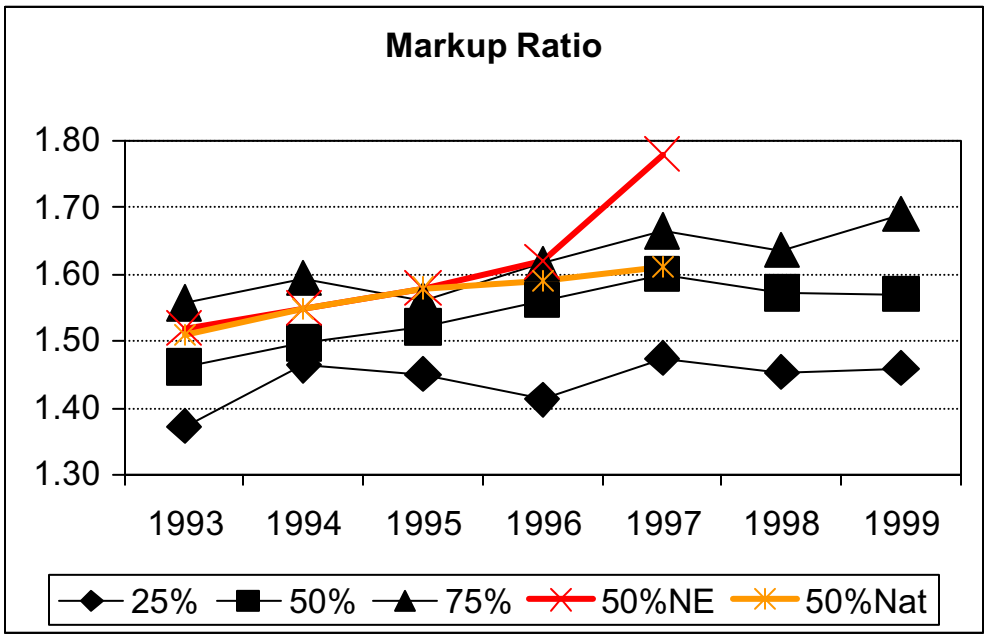


Figure 5

However, it appears that New Hampshire hospitals tend to discount much less than do hospitals nationally. Median discounts off charges under contractual agreements with third parties are between 30% and 38% less in New Hampshire than nationally (see Figure 6). The table below Figure 6 compares the national median markups and deductibles to those of New Hampshire. While New Hampshire hospitals do not appear to discount as steeply as hospitals elsewhere, the

trend in the deductible ratio is gradually rising, and in 1999 the deductible rises a few percentage points in all quartiles, while the markup remains unchanged. This 1999 trend in the deductible and markup is an indication that third parties are starting to squeeze hospitals more than they have in the past, which contributes to the drop in operating margins seen in 1999.

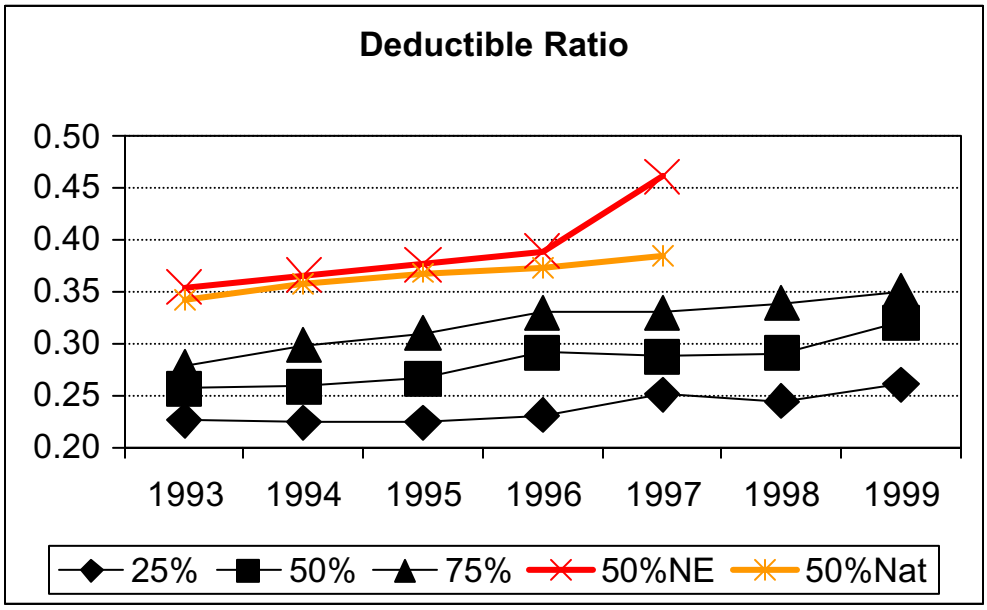


Figure 6

	1993	**1994**	**1995**	**1996**	**1997**
Markup:					
National 50% (% above NH)	1.51 3.4%	1.55 3.3%	1.58 3.9%	1.59 1.9%	1.61 .6%
New Hampshire 50%	1.46	1.50	1.52	1.56	1.60
Deductible:					
National 50% (% above NH)	.34 30.7%	.36 38.5%	.37 37%	.37 27.5%	.39 34.5%
New Hampshire 50%	.26	.26	.27	.29	.29

Figure 7 shows the proportion of total surplus (deficit) that comes from nonoperating revenues, which includes investment income, realized gains, and unrestricted donations (noncapital). New Hampshire hospitals realize a significant proportion of their total net income from nonoperating revenues, with median values ranging between 40% - 70%. The New Hampshire median for this ratio is just below the national median, which ranges between 50%-70% over time; and it is well below the regional median, which ranges between 70% – 160%. When this ratio rises above 100% it generally means that the hospital has operating losses, which are offset to some extent by nonoperating revenue. In 1999, roughly 25% of New Hampshire hospitals had nonoperating revenue ratios in excess of 100%. Lower values of nonoperating revenue to total profit generally indicate a more sustainable profit performance, in that more profit is generated by operating income. This ratio complements the information provided earlier in Figures 1 (total margin) and 2 (operating margin). One can conclude that, relative to hospitals regionally and nationally, New Hampshire hospitals rely more on operating profits and have higher operating and total profits over the period of our analysis, although in 1999, reliance on nonoperating profits increases significantly (no national comparison available).

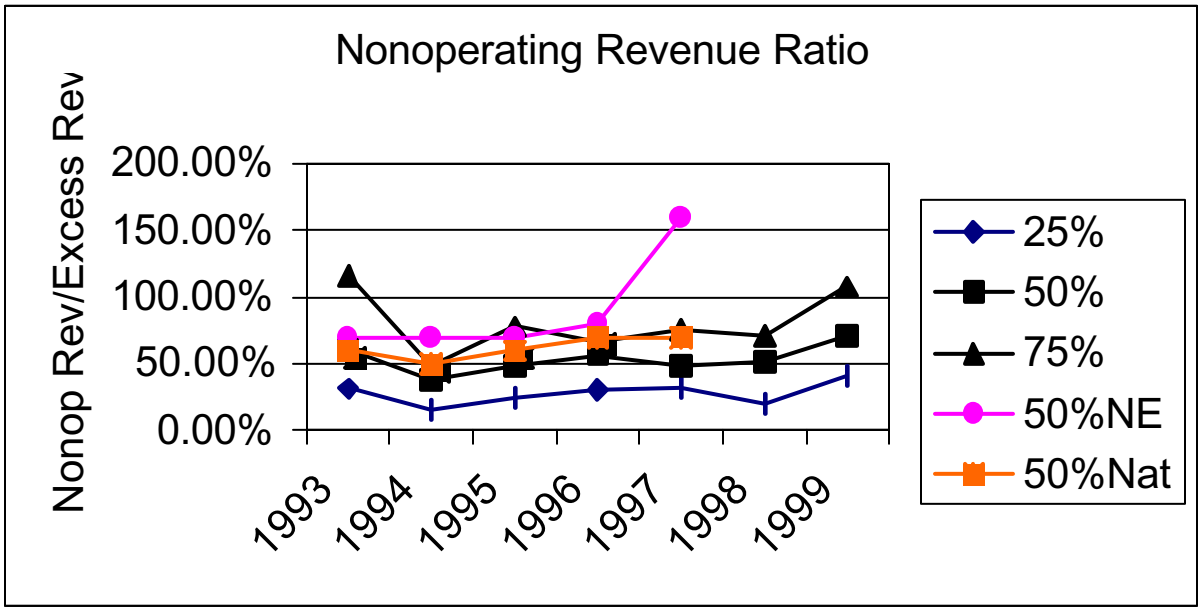


Figure 7

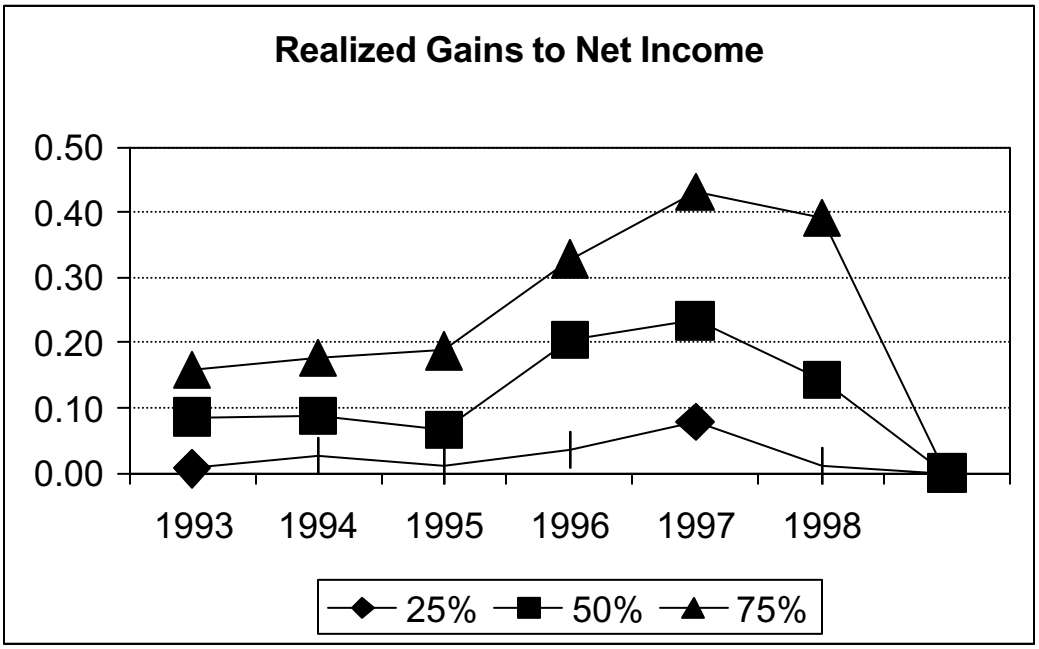


Figure 8

Figure 8 elaborates on the concept of nonoperating contribution to net income; it shows the proportion of net income that came from one element of investment income – realized gains. Realized gains (losses) represent the difference between the purchase value of marketable securities (stocks and bonds) and their selling price (when actually sold). This figure shows that realized gains contribute significantly to net income, especially in 1996 and 1997; for 50% of New Hampshire hospitals, realized gains represented 15 – 20% or more of their net income between 1996 – 1998. This source of income reflects the performance of capital markets and of the hospital's investment strategy, rather than how well the hospital is doing in its central mission of providing patient care. It cannot be expected to be maintained in a downturn affecting capital markets. A drop-off in realized gains, or incurring realized losses, could contribute to a drop in the future profitability of the hospitals, regardless of how the hospital is doing in providing patient care.

Table 1

	1993	1994	1995	1996	1997	1998	1999
Gross Patient Service Revenue	1331883	1400353	1523224	1574977	1665449	1776052	.
Less Revenue Deductions:							
Free Care	30651	30687	32134	31907	31751	28062	29135
Bad Debt	50909	55981	57197	58505	62860	66875	67482
Contractual Adjustments	339131	358985	402124	433765	480570	514647	.
Net Patient Service Revenue	911192	954700	1031769	1050800	1090268	1166468	1101249
Other Operating Revenue	21353	26026	31260	38887	40021	46958	47642
Total Operating Revenue	932545	980726	1063029	1089687	1130289	1213426	1148891
Operating Expenses:							
Depreciation & Amortization	58035	61907	68216	70313	68918	73839	70217
Interest	24580	24626	26429	25726	25439	25321	23014
Other Operating Expenses	827244	840785	923573	956540	994358	1098287	1044745
Total Operating Expenses	909859	927318	1018218	1052579	1088715	1197447	1137976
Operating Income*	22686	53408	44811	37108	41574	15979	10915
Nonoperating Revenue:							
Investment Income	22105	19555	27422	46403	70338	53962	.
Gains/Losses	-1476	-2727	3847	-439	-1059	7552	.
Other	4142	6260	8200	3128	3424	3816	.
Total Nonoperating Revenue	24771	23088	39469	49092	72703	65330	63688
Excess Revenue Over Expense	47457	76496	84280	86200	114277	81309	74603
	*Estimated sources of Op Income:						
Medicare PPS		-23417	-15976	-14323	-10932	-21345	
Non Medicare PPS		76825	60787	51431	52506	37324	

Percentage Changes:	**1994**	**1995**	**1996**	**1997**	**1998**
Gross Patient Service Revenue	0.05	0.09	0.03	0.06	0.07
Less Revenue Deductions:					
Free Care	0.00	0.05	-0.01	0.00	-0.12
Bad Debt	0.10	0.02	0.02	0.07	0.06
Contractual Adjustments	0.06	0.12	0.08	0.11	0.07
Net Patient Service Revenue	0.05	0.08	0.02	0.04	0.07
Other Operating Revenue	0.22	0.20	0.24	0.03	0.17
Total Operating Revenue	0.05	0.08	0.03	0.04	0.07
Operating Expenses:					
Depreciation & Amortization	0.07	0.10	0.03	-0.02	0.07
Interest	0.00	0.07	-0.03	-0.01	0.00
Other Operating Expenses	0.02	0.10	0.04	0.04	0.10
Total Operating Expenses	0.02	0.10	0.03	0.03	0.10

Table 1 (continued next page)

Operating Income*	1.35	-0.16	-0.17	0.12	-0.62
Nonoperating Revenue:					
Investment Income	-0.12	0.40	0.69	0.52	-0.23
Gains/Losses	0.85	-2.41	-1.11	1.41	-8.13
Other	0.51	0.31	-0.62	0.09	0.11
Total Nonoperating Revenue	-0.07	0.71	0.24	0.48	-0.10
Excess Revenue Over Expense	0.61	0.10	0.02	0.33	-0.29
*Estimated sources of Op Income:					
Medicare PPS		0.32	0.10	0.24	-0.95
Non Medicare PPS		-0.21	-0.15	0.02	-0.29

Table 1, continued

Table 1 shows the aggregate income statement of the 24 hospitals in New Hampshire by year through 1998, and for 22 hospitals in 1999 (1 of which did not report gross patient service revenue, and 2 did not report the details of nonoperating revenues). The bottom half of the table shows annual percentage changes of each income statement element through 1998 (1999 year is missing 2 hospitals, so changes were not calculated). Total operating revenues have grown as fast or faster than total operating expenses in 3 of the six years; operating income peaked in 1994, and has since shrunk for three out of the past four years. The primary contributor to the shrinking of operating revenues has been a reduction in non-Medicare-PPS profits, which peaked at $76.8 million in 1994, falling to an estimated $37.3 million by 1998. Medicare PPS losses peaked in 1994, and steadily improved until 1998 (the 1998 figures are estimates; we did not have a full set of 1998 Medicare cost reports). Then in 1998, Medicare PPS losses jump by roughly $10 million, by our estimates which are based on 1997 data and take into account the 1997 Balanced Budget Act effects on 1998 Medicare revenues.

Excess Revenue over Expenses grew every year except 1998; growth in nonoperating revenue was very high over the period 1995 – 1997.

The level of free care (valued at charges) provided did not change very much throughout the period, and actually dropped by 12% in 1998 over 1997.

In sum, for the period 1994 – 1997, New Hampshire hospitals enjoyed a very prosperous period, deriving largely from strong operating profits, but benefiting as well in more recent years from

nonoperating revenues driven primarily by investment income which includes realized gains. Non-PPS payers are providing the profits, which are more than offsetting aggregate PPS losses. However, in 1998, operating margins dropped for at least 50% of the hospitals, and in 1999, the operating margins drop in all quartiles. While the top 25% of hospitals continue to enjoy strong operating performance, starting in 1998 and continuing on in 1999, the bottom 25% appeared to be losing money on operations for the first time since 1993. As mentioned in the discussion about Table 1, the Medicare Balanced Budget Act contributes to this drop in operating profit in 1998, but non-PPS profits have been steadily eroding since 1994, contributing to the downturn in margins to a greater extent than have Medicare PPS losses.

Liquidity

Figure 9 represents the distribution of values of the current ratio (current assets/current liabilities), a measure of how well the hospitals can meet their current obligations with available and relatively liquid assets (cash, short term investments, accounts receivable, inventory). The New Hampshire hospitals do much better than the region (regional median is roughly equal to the New Hampshire bottom quartile of 1.5), and the state median is slightly better than the national median current ratio.

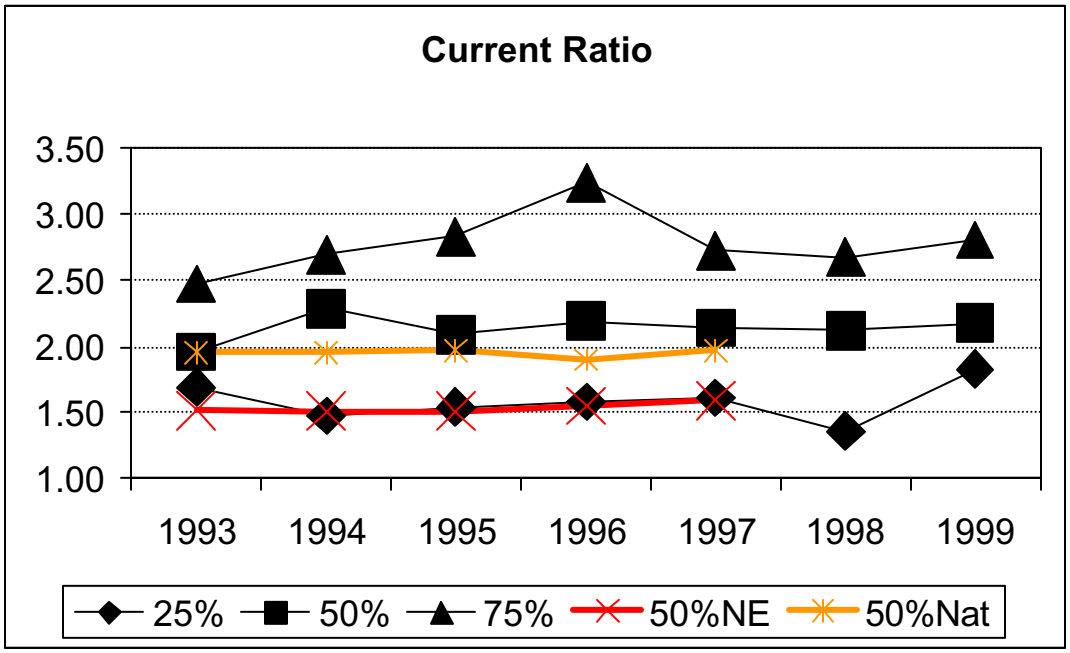


Figure 9

A high current ratio is generally considered good, although if it is high because of slow collection of receivables, this is unfavorable. Figure 10 shows the days of net patient service revenue that remain in accounts receivable; lower days are a positive sign. New Hampshire hospitals appear to be collecting revenues as fast as their regional counterparts, and faster than do hospitals nationally – a favorable sign through 1997. However in 1998 and more so in 1999, days in accounts receivables jump significantly. The cash implications of the slowdown become apparent in 1999, discussed further in the section, *Sources and Uses of Cash.*

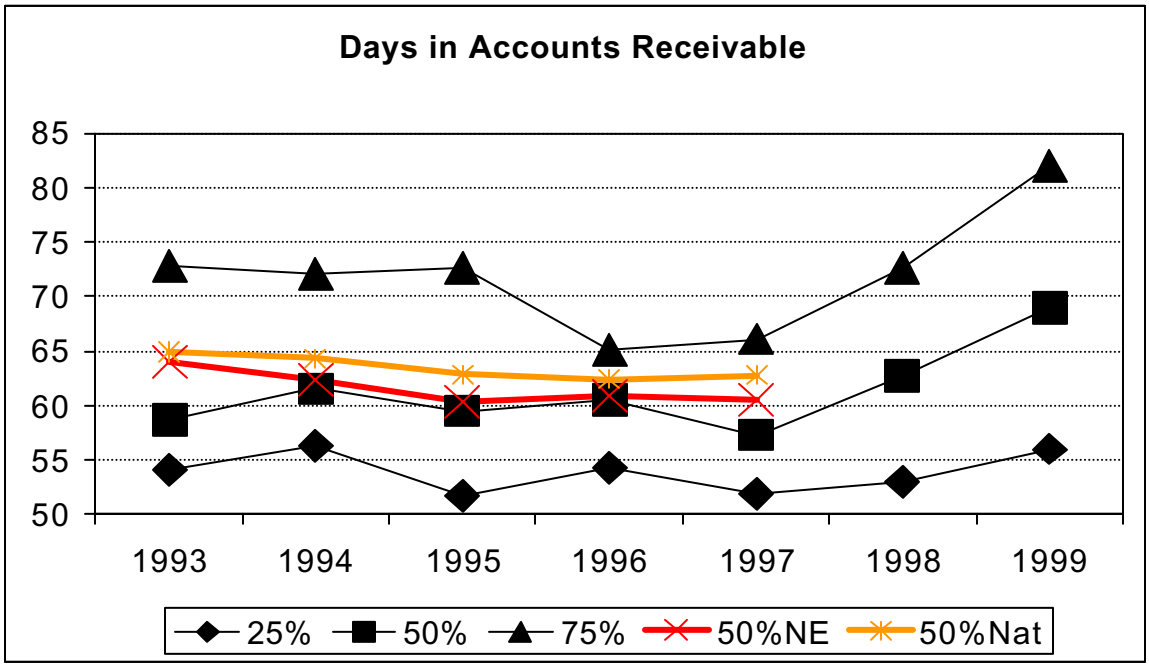


Figure 10

Figure 11 indicates how fast hospitals are paying their employees and vendors. 50% of hospitals are paying within 40 days or less of incurring the obligation to pay. While there is no comparable regional or national statistic, 40 days is a fairly reasonable payables cycle, and was steady from

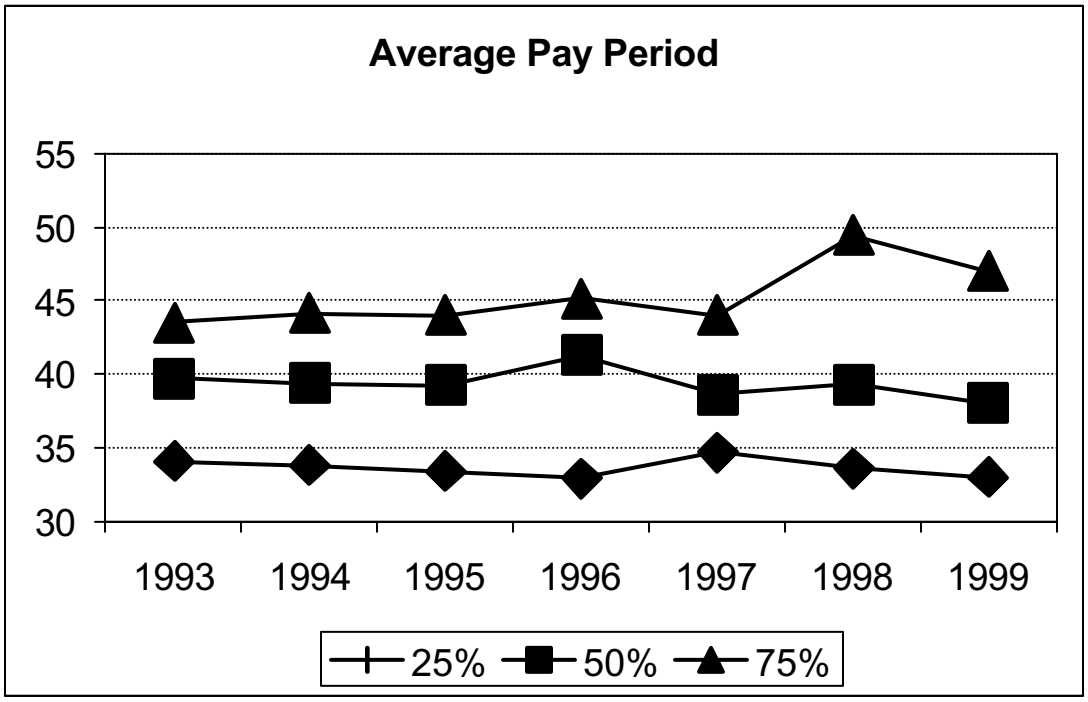


Figure 11

1993 – 1997. In 1998, the slowest quartile jumps to 50 days or higher; only one of the hospitals with days payable over 50 has a days cash on hand below 100, so the slowdown does not appear to be driven by a cash shortage. Despite the slowdown in collection of receivables in 1999, the average pay period does not change in 1999.

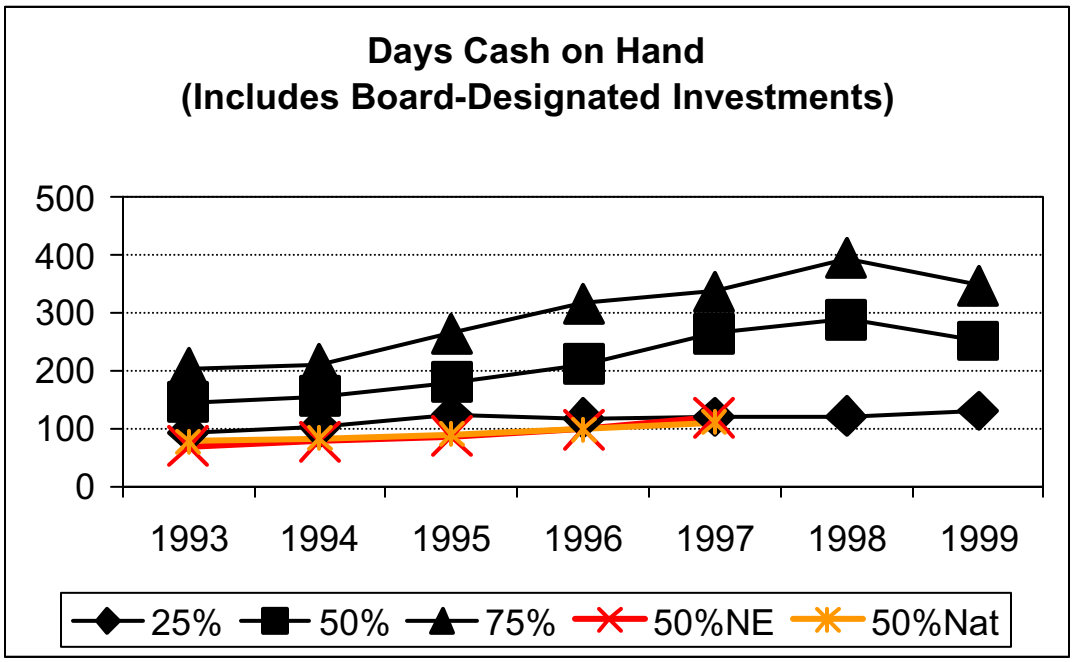


Figure 12

Figure 12 represents days of operating expenses available in cash on hand. New Hampshire hospitals have significantly higher days of cash on hand than do hospitals regionally or nationally. While the regional and national median trends upward from around 70 days in 1993 to almost 100 days in 1997, the median in New Hampshire is more than twice that, and rising much faster over time. By 1998, 50% of New Hampshire hospitals had cash balances of 300 days or more. 25% of hospitals in New Hampshire could continue to operate for over a year without any additional cash coming in. However, those in the bottom quartile have days cash on hand of 125 days or less; still very liquid. Only two hospitals have days cash on hand below 100 in 1998 (the lowest was 40). In 1999, average days cash decreases slightly for the 50th and 75th quartiles, but actually improves for the bottom 25% to 130 days cash on hand. The hospitals' cash position remains very strong in 1999.

In sum, hospitals in New Hampshire accumulated unusually high cash balances over the period 1993 – 1999, giving them very solid current ratios and days cash on hand that were well above regional and national values. Much of the cash on hand is in short- and longer-term investments, which contributes to the significant rise in investment income earned by the hospitals between 1994 and 1999.[10] However, an increase in the amount of time to collect accounts receivable becomes evident in 1998 and 1999, and this begins to affect the ability of the hospitals to generate additional cash in 1999.

Solvency

Figure 13 represents the equity financing ratio, or the amount of equity relative to total capital on the balance sheet. The New Hampshire median value, which ranges between 55% - 65%, is above both the regional and national medians. New Hampshire hospitals are less reliant on debt than most other hospitals in the country. However, the trend for the bottom quartile is downward in 1998 and 1999, due to losses eroding their equity base.

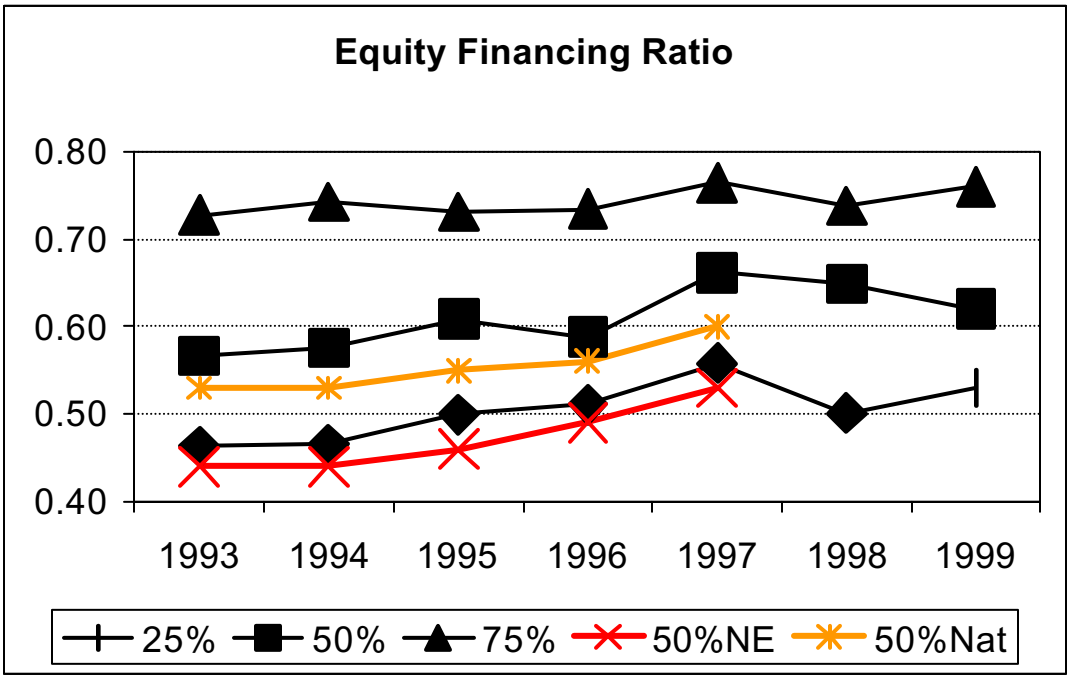


Figure 13

[10] The cash balances as of 1998 include very little Medicaid Enhancement Fund dollars; these are not the source of growth in cash balances over the period.

Coupling the relatively low debt with the relatively high profitability gives the New Hampshire hospitals very favorable cash flow to total debt ratios. As can be seen in Figure 14, since 1995 the median cash flow to total debt ratio has hovered around 30%, while the national median stayed below 20% for the entire period. The regional median stayed below 20% as well. Thus, New Hampshire hospitals have relatively low financing risk, given their lower borrowing and higher debt servicing capabilities. However, declining margins in 1999 push the trend downward; the bottom quartile of hospitals had cash flow to total debt ratios below 14%. Three of those hospitals have cash flow to total debt ratios below 10%, and one of those is negative. While this is certainly a red flag, the hospital with the negative ratio has twice as much cash as it owes in long-term debt, so insolvency is not an immediate concern.

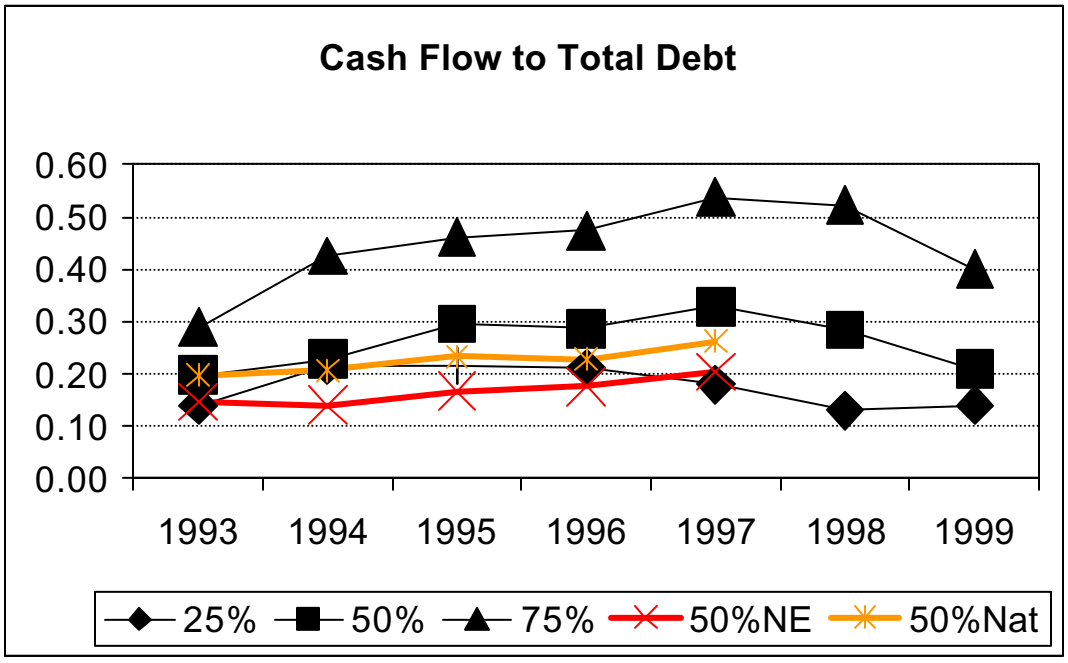


Figure 14

The higher liquidity and lower debt experience of New Hampshire hospitals has not been achieved at the expense of investment of property plant and equipment for the most part, as Figure 15 illustrates. The median average age of plant in New Hampshire is well below national and regional medians. The oldest quartile in New Hampshire approximates the oldest 50th percentile in value in the region; however, since 1996, the oldest quartile is a half year older than the national median. In 1999, plant age improves slightly for the older hospitals, while the youngest hospitals age only slightly, which are positive trends.

The solvency and plant age ratios are further evidence that the period 1993 – 1999 has been one of relative prosperity with less financial risk than hospitals regionally and nationally have had to undertake. However, the financial peak was in 1997; the bottom quartiles of hospitals in particular, are trending downward in key solvency indicators. The cash flow pattern reinforces these conclusions.

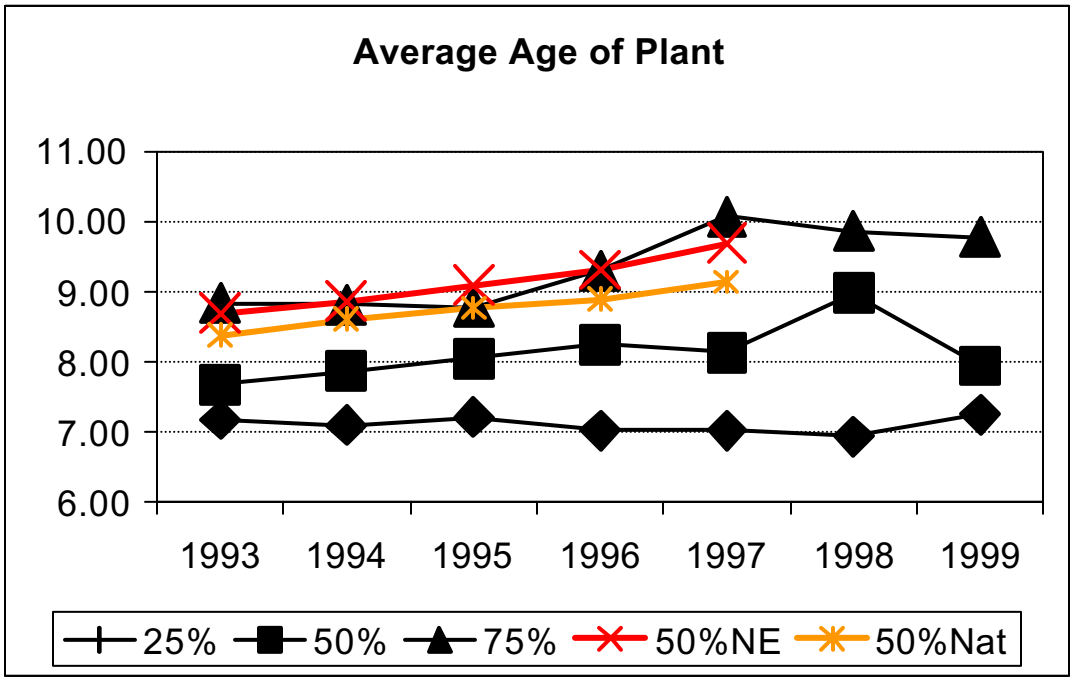


Figure 15

Sources and Uses of Cash, 1993 –1998

Table 2 provides the 6 year cumulative and aggregated cash flows for the 24 nonprofit hospitals in New Hampshire over the period 1993 – 1998. *Sources* of cash support the conclusion from the ratios that the hospitals are generally very healthy; and the number one *use* of cash is increasing cash and marketable securities, indicating that the hospitals have enjoyed a period of prosperity that has given them significant cash reserves against future adversity.

Table 2 Cash Sources and Uses, 1993-1998

Sources	$ 000	%	Uses	$000	%
Operating Income	215,566	20	Increase Cash and Marketable Securities (unrestricted)	508,835	46
Nonoperating Revenue	274,453	25	Investment in PP&E	455,715	41
Depreciation and Amortization	422,349	38	Affiliate Investments, Receivables and Equity Transfers	124,764	11
Net Working Capital	24,683	2	Other Uses	13,448	1
Net Long Term Debt	91,601	8			
Restricted Fund Transfers	39,535	4			
Sale of Assets and Other Noncurrent Assets	34,575	3			
Total Sources	1,102,762		Total Uses	1,102,762	

Cash from operating activities includes cash from operating income, nonoperating revenue, depreciation and amortization (expenses that lower operating income but do not require the use of cash), and working capital (primarily changes in receivables, inventory, accounts payable, estimated third party liabilities). Cumulatively over the six years, 85% of total cash generated by the hospitals was from operating activities. Only 12% was from outside capital sources (long term debt – 8%- and restricted funds (capital donations) - 4%). Only 3% was from the sale of assets (e.g., the sale of marketable securities in excess of the purchase of new securities).

The number one use of cash was investing in additional unrestricted cash and marketable securities. Forty-six percent of the cash generated over the six years was kept in cash or marketable securities, raising cash balances statewide by over $500 million. Another 41% was invested in property, plant, and equipment. This capital investment was only 8% above the amount written off as depreciation and amortization over 6 years. The level of capital spending suggests that some hospitals are not maintaining historical levels of investment in property, plant and equipment, given that depreciation is on an historical cost basis, while new property and equipment acquisition is on a market level or replacement cost basis (generally higher than historical cost basis). Clearly the restraint in capital investment is not because hospitals do not have the cash or debt capacity to invest more. It is more likely to be a sign that hospitals have excess capacity (i.e., there may be lower demand for inpatient care, so maintaining that level of investment is not wise), and/or that hospitals are choosing to maintain their liquidity in the face of future uncertainty, rather than increase their fixed costs and their financial risk.

Over the six years, hospitals have invested roughly $125 million in their affiliates, through a variety of instruments (notes, transfers, and investments). These affiliates consist of parent organizations, foundations, physician practices, physician-hospital organizations, physician joint ventures (lab, imaging, ambulatory surgery centers), sports medicine, home care, long-term care, life care, senior housing, pharmacy management, real estate ownership and management, and athletic clubs. They also involve multiple hospitals as affiliates within a larger system organization. Most of the hospitals in New Hampshire have at least one affiliate organization.

The cash flow picture is one of considerable strategic flexibility, and again supports the view that the industry is quite healthy financially over this period. However, the picture emerging from the 22 hospitals with data available in 1999 indicate some slowdown in additions to the cash prosperity. As the table below indicates, 1999 operating income is a significantly smaller contributor to cash, while nonoperating revenues contribute much more as a percentage of total sources. Working capital shifts from being a small *source* of cash to becoming a major *use* (25%) of cash, driven primarily by the increase in accounts receivables. This reduces the ability of the hospitals to increase cash and marketable securities, which shrink significantly as a use of cash to only 8%. Meanwhile, investments in property, plant, and equipment increase to 51% of uses, up from 41%, and consistent with the steady to improving trends in plant age for most hospitals. While the 1999 cash flow is still one of strategic flexibility, some strains are beginning to show.

Sources of Cash, 1999	**$000**	**% Total**	**Uses of Cash, 1999**	**$000**	**% Total**
Operating Income	10,915	6%	Investment in PP&E	92,783	55%
Nonoperating Revenue	63,688	38%	Working Capital	41,743	25%
Depreciation and Amortization	70,699	43%	Affiliate Transactions	19,621	12%
Longterm Debt, Net	12,496	7%	Increase cash & Marketable Securities	12,971	8%
Restricted Fund Transfers	10,070	6%	Other Noncurrent Assets & Liabilities	750	LT 1%

Community Benefit Benchmarks

Findings

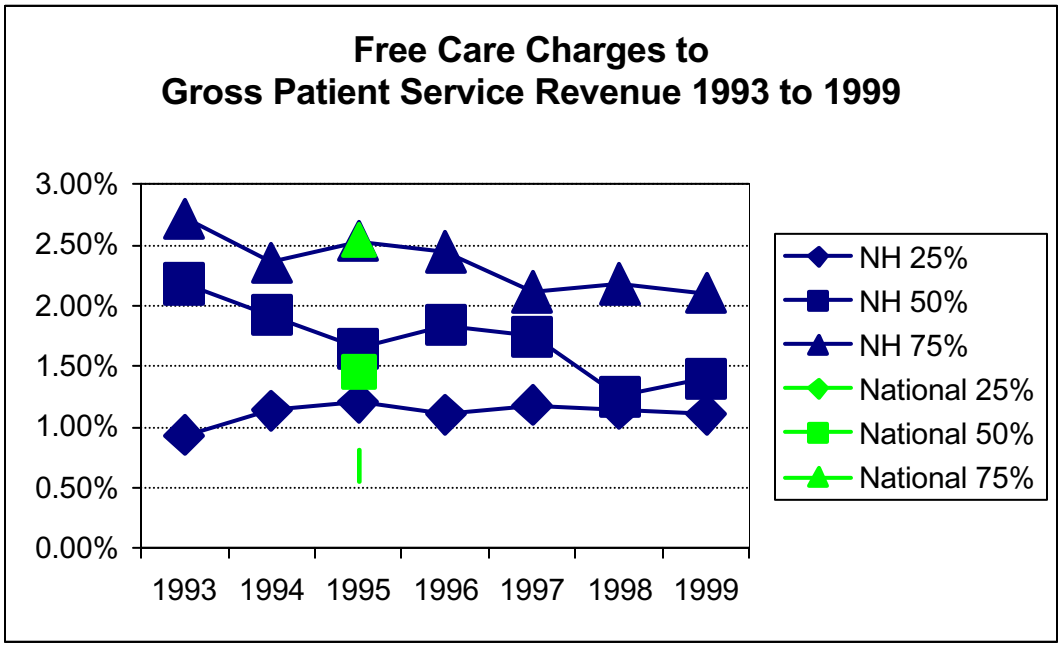


Figure 16

Figure 16 shows the ratio of free care, valued at charges, to gross patient service revenue. This is compared to a 1995 national database of 500 hospitals (Kane, 2000) for which free care data were collected as part of a previous research project. Two observations can be made about this value in New Hampshire; one, it is declining over time for between 50-75% of hospitals; and two, the the values in 1995 are similar to or slightly above the national sample. 1999 values do not change significantly from those of 1998.

Figure 17 shows total bad debt, valued at charges, to gross patient service revenue, and makes the comparison again to the 1995 data base mentioned above. The observations here are: one, the ratio appears to be fairly steady over time, with the 25th and 75th percentiles hovering in the 3% and 4.5% range over the period; and two, that the distribution of values is quite a bit higher than the national distribution. In 1995, the bottom 25% of hospitals in New Hampshire had bad debts of around 3% or less of gross revenue, while nationally, 50% of hospitals were below roughly 2.5 percent. Bad debts as a percentage of charges rise in all quartiles in 1999.

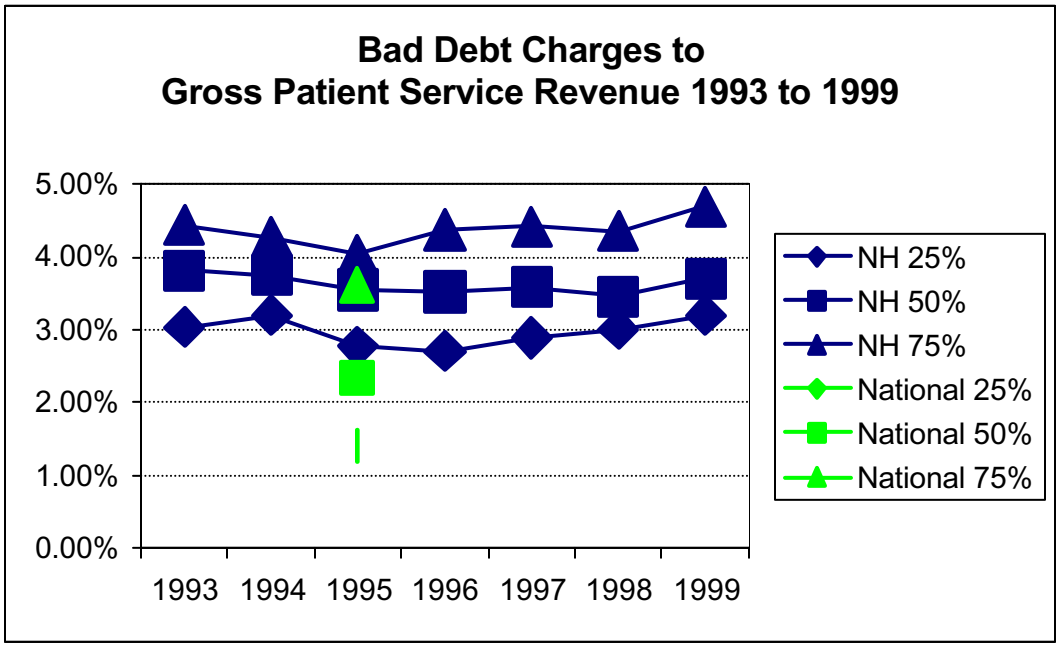


Figure 17

Figure 18 represents the ratio of free care, valued at cost, over the value of the tax benefit (summing the four taxes identified earlier). A number of observations can be made from this chart: first, that for most hospitals the ratio has been declining until 1998; second, that for more than 75% of hospitals in New Hampshire, the amount of free care, valued at cost, is below the value of tax exemptions. However, for a few hospitals (5 in 1998), the value of free care exceeds the value of tax exemptions, by substantial amounts (1.32 to 2.69 times). The median value (50 % are above and 50% are below) is roughly .5, that is, the cost of free care is roughly 50% of the value of the tax exemption.

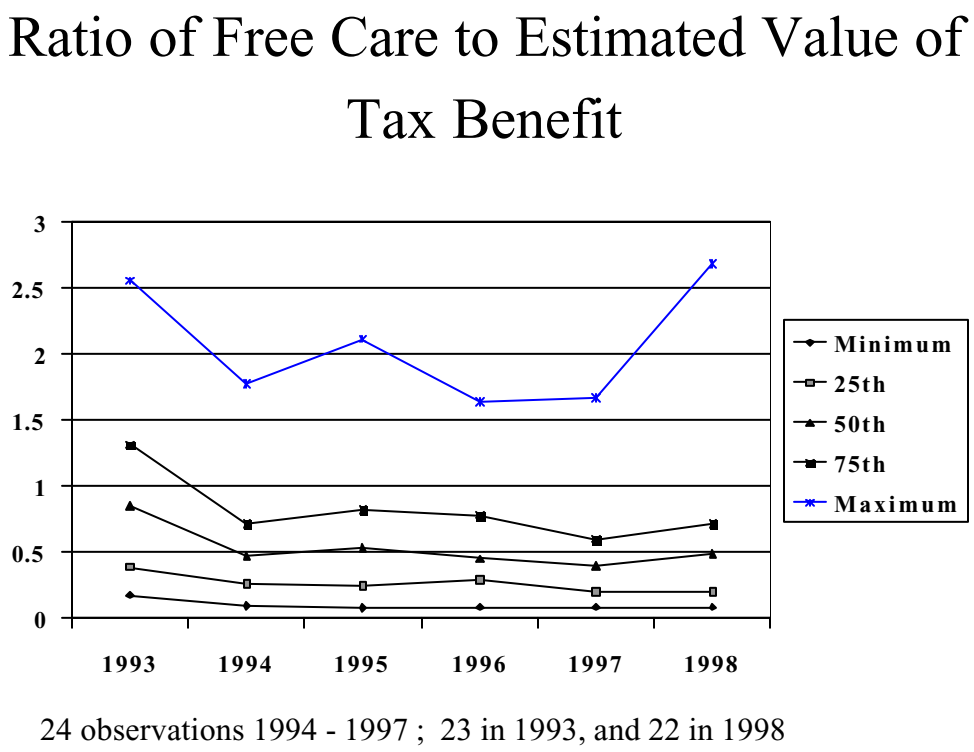
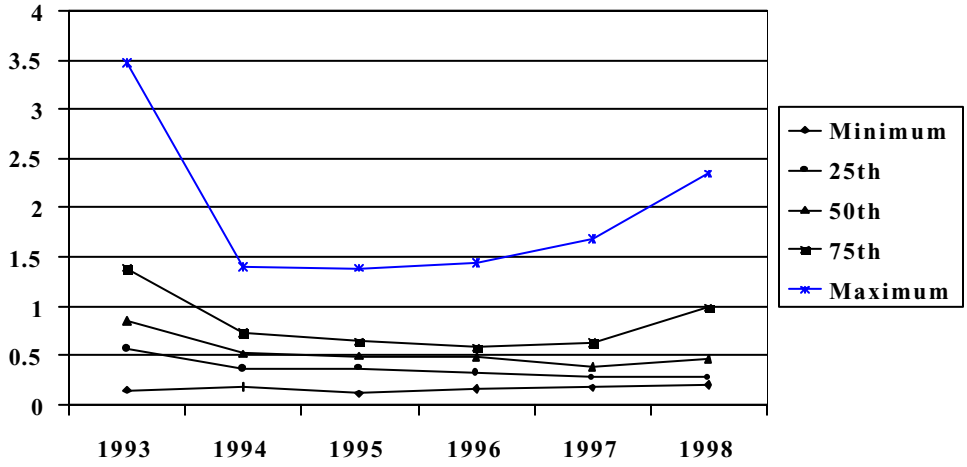


Figure 18

Figure 19 shows the ratio of bad debt, valued at cost and recognizing the 50% that might convert to free care status in the future if policies change. This value shows similar trends to the free care ratio: slightly declining until 1998, a 50% value for the median most years, and a few hospitals (the same five with high free care ratios in 1998) with ratios well above one.

Ratio of 50% of Bad Debt Cost to Estimated Value of Tax Benefit



24 observations 1994 - 1997, 23 in 1993, 22 in 1998

Figure 19

The estimated Medicaid shortfalls [11] are compared to the value of tax exemption for 1998 only. For roughly 83% of hospitals, Medicaid shortfalls were less than the value of tax exemptions; the median value of the Medicaid shortfall/tax value was 32%. Four hospitals had shortfalls that exceeded the estimated value of tax exemptions. Whether Medicaid shortfalls should or should not be considered part of a hospital's "community benefit" is a policy issue that has several pros and cons. "Pro's" include the fact that Medicaid payment policy has historically been set to cover less than a hospital's full cost to cover Medicaid patients; and that the beneficiaries are low income people. The "con" is that Medicaid is not a service uniquely provided by nonprofit hospitals; in many states, for-profit hospitals serve as high or higher a proportion of Medicaid patients as nonprofit hospitals (Kane, 1999). This is not generally true of free care; nonprofits generally provide more free care than do investor-owned hospitals.

[11] The Office of Planning and Research calculated an estimate of Medicaid shortfall for 1998 using actual Medicaid inpatient and outpatient charges and a Medicare Cost Report-derived cost-to-charge ratio. The results suggest that hospitals in NH are paid – on average – somewhere between 62-66% of costs for inpatient charges for a total shortfall of approximately $30 million or an unweighted average of $1.2 million per hospital. (NOTE: all hospitals receive 91.3% of costs-to-charges for outpatient services.)

All three of the values of free care, 50% bad debt, and Medicaid shortfall, are compared to tax benefits for 1998 only. Summing all three measures, 29% (7) hospitals have ratios below one (fail to provide community benefits equal to or greater than the value of tax exemption) in 1998.

In terms of essential community services, we found that no hospitals reported that they provided inpatient burn units, two hospitals were classified as teaching hospitals, three hospitals offer neonatal intensive care services, 12 provide trauma services, and 14 provide HIV services. Of the seven hospitals with total community benefit/tax benefit ratios below 1 in 1998, one reported HIV and trauma, one other trauma, and two HIV. Three had none of these services.

In sum, the community benefit benchmarks provide a perspective, in that they emphasize the need for state policymakers and communities to identify what they consider to be their communities' highest priority needs. To the extent that providing free care to the uninsured is a high priority, it appears New Hampshire hospitals provide about as much free care as is provided nationally as a percentage of gross revenue, but that the level of free care has fallen during a period of relative prosperity in the industry. For 75% of hospitals, the level of free care is well below the value of the benefits of tax exemptions. However, to the extent that bad debt and Medicaid shortfalls are considered high community need priorities, 17 (roughly 70 %) of hospitals provided levels of these benefits in excess of the value of their tax exemptions in 1998 (including free care). Bad debts/charges is high relative to available national levels. There is no comparable national comparison for Medicaid shortfalls.

Urban/Rural Performance Comparisons

The financial and some free care benchmarks were compared (using t tests) for significant differences between urban and rural hospitals. The following table summarizes the benchmark findings:

Ratio:	Difference between Urban and Rural:	Direction if Significantly Different:
Total Margin	Not significantly different	
Operating Margin	Not significantly different	
Markup Ratio	Significantly different	Rurals have lower markups
Deductible Ratio	Significantly different	Rurals have lower deductibles
Nonoperating Revenue Ratio	Not significantly different	
Current Ratio	Not significantly different	
Days in Accts Receivable	Significantly different	Rurals collect more slowly
Days in Accts Payable	Significantly different	Rurals pay more quickly
Days Cash on Hand, Including Board Designated Cash	Not significantly different	
Equity Financing Ratio	Significantly different	Rurals have relatively more equity
Cash flow/total Debt	Significantly different	Rurals have higher cash flow to total debt ratios
Average Age of Plant	Significantly different	Rurals have older plant
Free Care/Gross Revenue	Significantly different	Rurals provide less free care as a % of gross revenue

The benchmark ratios indicate that rural hospitals are generally just as profitable as the urban hospitals. They have just as much cash on hand, even though they collect their receivables more slowly and pay their bills more quickly, and they borrow less (particularly long-term debt). They also have older plants, which is the trade-off they face for having less long-term debt as a proportion of their capital structure. Finally, the rural hospitals provide a lower proportion of gross revenue as free care.

Conclusion

The financial and community benchmarks presented here present an historical analysis of New Hampshire hospitals over a period of relative prosperity – the mid-1990's. It will be important to link this analysis up with others being undertaken as part of the Department of Health and Human Services' larger project, looking at the competitive marketplace within which New Hampshire

charitable health care organizations operate. This study raises a number of questions that can be better answered once the results of the other research projects are complete:

- How were hospitals able to be so profitable over this period? Is it due to highly efficient operations (low costs) or to an ability to maintain high prices relative to costs?
- How can hospitals justify the accumulation of so much cash on their balance sheets, constituting 46% of all cash generated over a 6 year period? What do they plan to do with these resources?
- Why was the level and relative amount of free care provided level or declining over this period? Are there fewer uninsureds and, therefore, less need for free care? Are there obstacles facing the uninsured to receiving free care? It is hard to argue, based on the results of this analysis, that hospitals have been unable to provide more free care due to financial hardship.
- Finally, there are 3 – 5 hospitals whose financial performance has not been so prosperous; and they are consistently among the hospitals providing the highest levels, relative to their tax benefits, of quantifiable community benefits. Should these hospitals be in some way assisted financially? If they were to fail to survive, what would be impact be upon the "safety net" for New Hampshire's most vulnerable citizens?

Appendix A

	A	B	C	D	E	F	G	H
1	HOSPNAME							
2	FYEND							
3	YEAR							
4	**BALANCE SHEET, UNRESTRICTED FUND ($000s)**							
5	CURRENT ASSETS							
6	Cash and Investment							
7	Cash and Investment-Board Designated							
8	Cash and Investment-Trustee Held							
9	Current Assets Whose Use Is Limited							
10	Receivables:							
11	Net Patient Accounts Rec							
12	Due from Affiliates							
13	Third Party Settlemt Rec							
14	Other Accounts Rec							
15	Inventory							
16	Other Current Assets							
17	Total Current Assets							
18	NONCURRENT ASSETS							
19	Assets Whose Use Is Limited:							
20	Trustee-held Investments							
21	Board-Designated & Undesignated Investments							
22	Due From Affiliates							
23	Investment in Affiliates							
24	Land & Bldgs held for investmnt							
25	Other Noncurrent Assets							
26	Gross PP&E							
27	Accum. Depreciation							
28	Net PP&E							
29	Total Noncurrent Assets							
30	TOTAL UNRESTRICTED ASSETS							
31	LIABILITIES AND EQUITY							
32	CURRENT LIABILITIES							
33	Current Long Term Debt							
34	Accounts Payable + Accrued Expenses							
35	Estimated Third-Party Settlements							
36	Due to Affiliate							
37	Other Current Liabilities							
38	Total Current Liabilities							
39	NONCURRENT LIABILITIES							
40	Long term debt							
41	Estimated Third Party Settlements							
42	Due to Affiliate							
43	Self-Insurance Fund							
44	Accrued Pension & Post-Retiree Health Bens							
45	Other noncurrent liabilities							
46	Total Noncurrent Liabilities							

	A	B	C	D	E	F	G	H
47	Fund Balance-Unrestricted							
48	TOTAL LIABILITIES AND EQUITY							
49	**RESTRICTED FUNDS ($000s)**							
50	Cash and Investments							
51	Receivables							
52	Other Assets							
53	Total Restricted Assets							
54	LIABILITIES AND EQUITY							
55	Total liabilities							
57	Temporarily restricted							
58	Permanently Restricted							
59	Total Restricted Fund Bal							
60	Total Restr Liab and Equit							

	A	B	C	D	E	F	G	H
61	**INCOME STATEMENT ($000s)**							
62	Gross Patient Service Revenue							
63	Free Care							
64	Bad Debt							
65	Contractuals							
66	Net Patient Serv Revenue							
67	Other Operating Revenue							
68	Total Operating Revenue							
69	OPERATING EXPENSES							
70	Depreciation							
71	Interest							
72	Other operating expenses							
73	Total operating expenses							
74	Net Operating Income							
75	NONOPERATING REVENUE							
76	Investment Income							
77	Gains/Losses-other							
78	Other inc (exp)							
79	Total nonoperating revenue							
80	Excess of revenue over expenses							
81	OTHER GAINS (LOSSES) DUE TO:							
82	Extraordinary Gains (Losses)							
83	Total Surplus/Deficit							

	A	B	C	D	E	F	G	H
84	**STATEMENT OF CASH FLOWS ($000s)**							
85	CASH GENERATED FROM OPERATING ACTIVITIES							
86	Total Surplus/Deficit							
87	Noncash expenses (revenues)							
88	Funds from Operations							
89	Decr (incr) Bd. Desig Cash							
90	Decr (incr) Trustee-Held Cash							
91	Decr (incr) Current Assets Limited Use							
92	Decr (incr) Accounts Rec							
93	Decr(incr) Affil Rec							
94	Decr (incr) 3rd Party Rec							
95	Decr (incr) inventory							
96	Decr (incr) other current assets							
97	Incr (decr) accts pay/accd exp							
98	Incr (decr) 3rd Party Settlement							
99	Incr (decr) Due to Afffiliates							
100	Incr (decr) Other Curr Liab except LTD							
101	CASH FROM WORKING CAPITAL							
102	Cash from operating activities							
103	CASH FROM INVESTING ACTIVITIES							
104	Decr (incr) Bd Designted Invstmt							
105	Decr (incr) TrusteeHeld Invstmt							
106	Decr (incr) Due From Affiliates							
107	Decr (Incr) Affiliate Investments							
108	Decr (Incr) PP&E Invstmt							
109	Decr (incr) Other Noncurrent Assets							
110	Decr (incr) PP&E gross							
111	Sale of Fixed Assets							
112	Cash provided (used) in investing activities							
113	Cash Position before Outside Financing Activities							
114	CASH FROM FINANCING ACTIVITIES							
115	Issue Long Term Debt							
116	Repay Long Term Debt (incl Current LTD)							
117	Incr (decr) Third Party Settlmt							
118	Incr(decr) Due to Affiliates							
119	Incr(decr) Pension, Self Insur							
120	Incr(decr) other Noncurrent Liabl							
121	Transfers from (to) restricted funds							
122	Transfers from (to) other entities							
123	Cash Provided (Used) Financing Activities							
124	Net Change in Cash							
125	rec							
126	dif							
127								

	A	B	C	D	E	F	G	H
128	**RATIOS**							
129	TotMargin							
130	OpMargin							
131	Markup							
132	Deductible							
133	Markup Adj for Deductible							
134	TotalOpExpense Growth							
135	TotalOpRev Growth							
136	NonopRev							
137	RealizedGains/NonOpRev							
138	RealizedGains/NetIncome							
139	ROA							
140	ROE							
141	CurrentRatio w/ Bd & Undesig Assts							
142	CurrentRatio w/o Bd & Undesig Assts							
143	Acid Test							
144	Days A/R							
145	Average Pay Period, AP&AE							
146	Average Pay Period, CL							
147	Days Cash on Hand, Current							
148	Days Cash on Hand, Incl BD							
149	Equity Financing Ratio							
150	CashFlow/TotDebt							
151	CashFlow/TotDebt w/OpIncOnly							
152	LongtermDebt/Equity							
153	Fixed Asset Fin							
154	DebtSvcCovTot							
155	DebtSvcCovTot w/ OpIncOnly							
156	TotAssetTurn							
157	FixedAssetTurn							
158	AvgAgePlant-Depr. only							
159	Reported Income Index							

	A	B	C	D	E	F	G	H
160	**CHARITY CARE**							
161	Bad Debt Charges/GPSR							
162	Free Care Charges/GPSR							
163	Free Care at Cost (000s)							
164	Bad Debt at Cost (000s)							
165	Property Assessment							
166	Mill rate							
167	Property Tax ($000s)							
168	Business Enterprise Tax ($000s)							
169	Business Profits Tax ($000s)							
170	Sales Tax ($000s)							
171	State Income Tax ($000s)							
172	Federal Income Tax ($000s)							
173	Tax Value ($000s)							
174	Free Care/Tax Value							
175	Free Care & 50% Bad Debt / Tax Value							
176	Free Care & 100% Bad Debt / Tax Value							
177	Free Care & Bad Debt & Medicaid / Tax Value							
178	All Quant. Charity & Bad Debt / Tax Value							
179	Additional Charity/Community Benefits Reported:							
180	Medicaid costs exceeding payments (000s)							
181	community svc programs (000s)							
182	Burn Care Services							
183	HIV/AIDS Services							
184	NICU							
185	Trauma Center							
186	Teaching							
187	COUNTY							
188	MEDIAN INCOME							
189	PAYER MIX:							
190	MEDICARE							
191	PRIVATE							
192	MEDICAID							
193	SELF							
194	OTHER							
195								

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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Contents:

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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:

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[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

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[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

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[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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Contents

The New Hampshire Health Care Plan

In 1995, the Legislature directed the Department of Health and Human Services (DHHS) to prepare "a comprehensive and coordinated system of health and human services as needed to promote and protect the health, safety and well-being of the citizens of New Hampshire" (RSA 126A). The DHHS Office of Planning and Research responded by creating a statewide Health Care Planning Process that involved more than 1000 New Hampshire residents in 7 community councils, 22 focus groups, 18 town meetings, and 4 symposia.

This planning effort culminated in the issuance of the October 1998 report, ***The New Hampshire Health Care System: Guidelines for Change***. The report set forth 27 recommendations designed to improve the State's ability to: monitor and manage the rapidly evolving health care system; increase communities involvement in and direction of the health care system; enhance the ability of the market to perform effectively; and assure that New Hampshire citizens have access to needed health care. *Guidelines for Change* established the direction and goals of the State Health Care Plan. ***The Health of New Hampshire's Community Hospital System: A Financial and Economic Analysis*** is another in the series of reports that constitute the New Hampshire Health Plan (see the following page for a complete listing of the reports issued to date and how to obtain copies).

Beginning in the fall of 1998, the Department of Health and Human Services began taking steps to implement the recommendations contained in the *Guidelines for Change*. One of the first action steps completed was the statewide Household Insurance Coverage and Access Survey (recommendation 2) that established a baseline estimate of New Hampshire's uninsured (see *Health Insurance Coverage in New Hampshire*).

Another major step in the implementation of the *Guidelines for Change* - the analysis of New Hampshire's health care market - began in the spring of 1999. The DHHS, Office of Planning and Research, partnered with the Department of Insurance and the Attorney General's Office to begin the joint monitoring of the health care market (Recommendation 1) and to develop a data system that provided information on the performance of the market (Recommendation 15). During this same time, the DHHS and the Attorney General's Office conducted a series of workshops on the new community benefits legislation (Recommendation 27).

The Health of New Hampshire's Community Hospital System: A Financial and Economic Analysis represents the second report to be released from the New Hampshire health care market analysis. The financial and economic analysis of New Hampshire's community hospitals responds to the *Guidelines for Change* recommendations

- (Recommendation 1) to monitor the health care market (a joint activity by the Department of Health and Human Services, Department of Insurance and the Office of the Attorney General);
- (Recommendation 2) to assess the effectiveness of the changing market in meeting the needs of the uninsured;
- (Recommendation 6) to explore the use of subsidies for the uninsured who cannot afford to purchase private health insurance;
- (Recommendation 10) to evaluate the adequacy of the health care delivery system; and
- (Recommendation 27) to implement the community benefits statute.

New Hampshire Health Care Plan Reports

The Elements of an Ideal Health Care Delivery System

An Inventory of Health Status Indicators

New Hampshire's Health Status Goals

Health Planning, Values and Preferences

The State, Communities, and Individuals: Roles and Responsibilities in New Hampshire's Health Care System

The New Hampshire Network Survey Report

Creating a Healthier New Hampshire: A Consumer Report on Proposed Changes to New Hampshire's Health Care System

The New Hampshire Health Care System: Guidelines for Change

Health Insurance Coverage in New Hampshire

Strengthening the Safety Net: A Financial Analysis of New Hampshire's Community Health Centers

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PREFACE

Nancy Kane, DBA, Harvard School of Public Health, prepared the *Analysis of Health Care Charitable Trusts in the State of New Hampshire* for the New Hampshire Department of Health and Human Services in cooperation with the New Hampshire Department of Insurance and the Office of the Attorney General. The Robert Wood Johnson Foundation, under the auspices of The Access Project, Grant Number 031275, funded this project. The author performed this work under subcontract to the Spitz Consulting Group, LLC.

Boyd Gilman, Ph.D., Senior Economist and Jerry Cromwell, Ph.D., President, Center for Health Economics Research, Waltham, MA, prepared *Assessing the Competitiveness of New Hampshire's Health Care Markets: A Focus on Hospitals* for the Department of Health and Human Services in cooperation with the New Hampshire Department of Insurance and the Office of the Attorney General. The authors performed this work under subcontract to the Spitz Consulting Group, LLC.

The Robert Wood Johnson Foundation, under the auspices of the State Coverage Initiatives Project, Grant Number 035401 to the Department of Health and Human Services (DHHS), also provided assistance.

Lori Real, MHA, Director, DHHS, Office of Planning and Research (OPR), provided overall direction for the New Hampshire health care market analysis, of which this project is one component.

Christine Shannon, MS, Senior Health Planning and Policy Analyst, DHHS, OPR, designed the market analysis project, managed the project team, participated in the day-to-day research, and contributed to the writing of this report.

Bruce Spitz, Spitz Consulting Group, LLC, assisted in securing the funds to do this work, developed the project team, and contributed to the writing of this report.

Steve Norton, Senior Health Policy Analyst, OPR, brought valuable technical skills and experience gained at the national level to the economic analysis component of this project. John Bonds, Planning Coordinator, OPR, supplied history and insights on the New Hampshire health care system, as well as his website expertise.

The Interagency Workgroup (a multi-State agency group composed of the Department of Health and Human Services, NH Department of Insurance and the Office of the Attorney General) partnered with the Office of Planning and Research to develop and sustain this project. They supported this work from the outset, assisted in the data collection and review of earlier report drafts, and contributed to the development of the recommendations. Numerous working sessions were necessary to complete this report, which could not have occurred without them. Members of the Interagency Workgroup are as follows: Donald Shumway, Commissioner, DHHS, Kathleen Sgambati, Deputy Commissioner, DHHS, John Wallace, Assistant Commissioner, DHHS, Paula Rogers, Commissioner, NH Department of Insurance, Alex Feldvebel, Deputy Commissioner, Department of Insurance, Phillip McLaughlin, Attorney General, Michael DeLucia, Assistant Attorney General and Director, Charitable Trusts, Terry Knowles, Registrar, Charitable Trusts, Walter Maroney, Senior Assistant Attorney General, and Tom Bunnell, Health Policy Advisor, the Governor's Office.

This report was also subject to technical review by national experts in health policy, health economics, community benefits, and community organization: Stuart Altman, Ph.D., Sol C. Chaikin Professor of National Health Policy, Heller Graduate School, Brandeis University, and Mark Schleshinger, Ph.D., Associate Professor of Public Health, Department of Epidemiology and Public Health, Yale University, Kevin Barnett, Ph.D., Director of Community Health Research and Policy Analysis, Public Health Institute, Berkeley, CA, and Catherine Dunham, Ed.D., Director, Access Project, and members of her staff that included Robert Seifert, Senior Policy Analyst, and Mark Rukavina, Deputy Director for Programs and Policy.

The Department thanks the New Hampshire Hospital Association and its members for their cooperation and participation in this project.

Special recognition and thanks are extended to Beth D'Ovidio, Therese Smith, Kelly Kimball, John Keegan, Don Dickey, Mike Dumond, and Jim Zibailo of the Office of Planning and Research for all of their contributions and hard work that made this report and the conference associated with its release possible. The Community Health Institute is also recognized for their assistance.

Purpose

New Hampshire's 26 acute care community and teaching hospitals are an integral part of the state's health care system. They provide a broad range of inpatient and outpatient health care services, represent the largest portion of expenditures in the medical delivery system (in 1998, hospitals accounted for 35 percent or 1.6 billion dollars in the state's 4.7 billion dollars in health care expenditures) and are major employers. New Hampshire's hospitals are predominantly charitable trusts (24 are nonprofit and 2 are for-profit). Traditionally, hospitals were providers of acute and emergent care services. However, the pressures from an evolving health care market have changed the hospitals' role. Today they are likely to be the key components of health care systems (or networks, alliances or affiliations) that include other providers such as skilled nursing facilities (SNFs), home health care agencies, physician practices, Community Health Centers (CHCs) and rehabilitation facilities.

The purpose of this report is to: (1) present the financial status and trends of the state's hospitals; (2) describe the characteristics of the health care market in which they function; (3) establish a method for monitoring the changes in the market (4) develop a baseline set of data for the new community benefit statute; and (5) propose recommendations to strengthen the financial status of hospitals that provide essential services in markets that have limited resources.

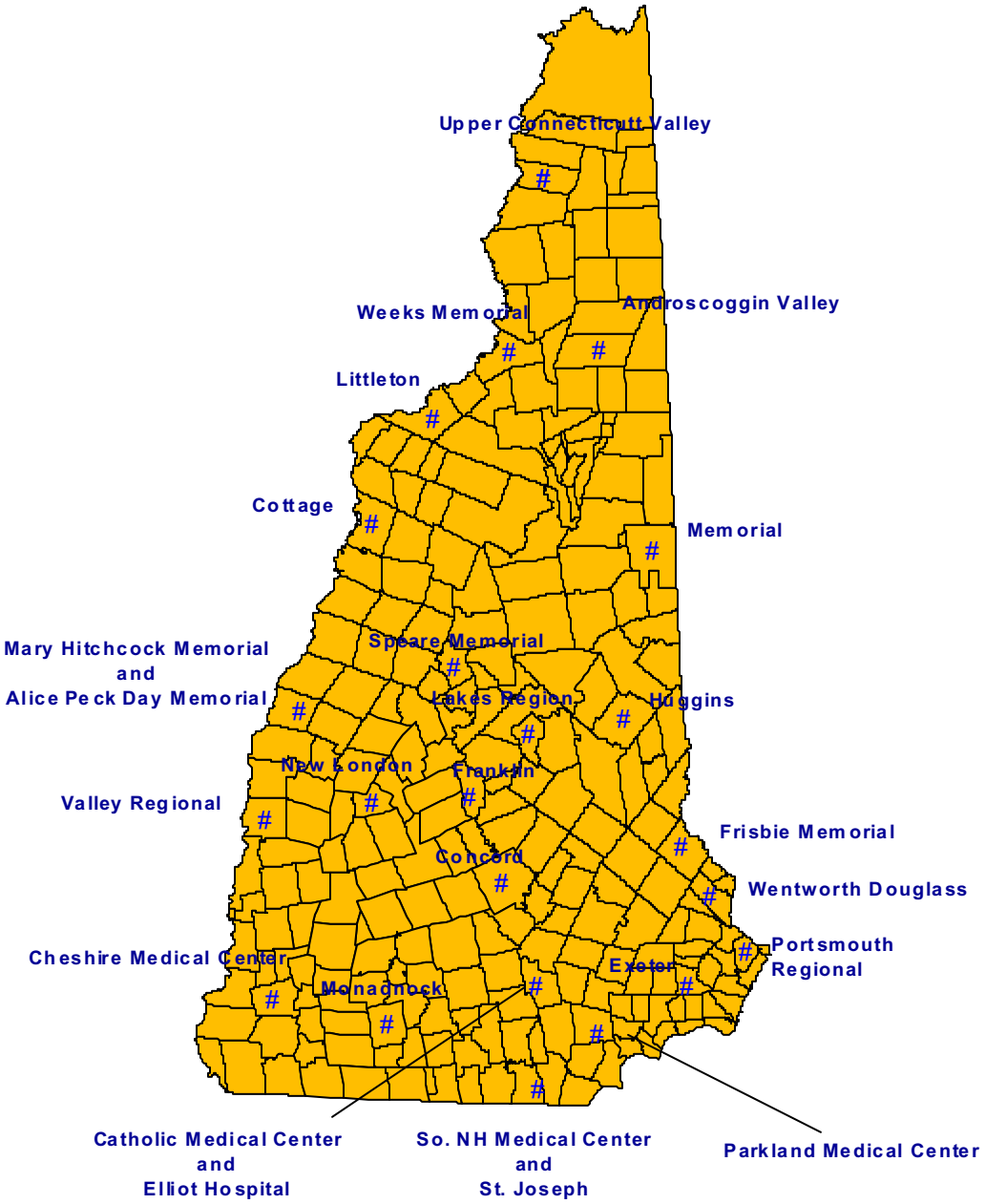
Introduction

During the 1990s, health care in New Hampshire has been characterized by a private restructuring of the market (increased competitive pressures, the creation of integrated hospital systems, and the consolidation of the insurance market); federal attempts to reduce public expenditures (the 1997 Balanced Budget Act and the subsequent 1999 Balanced Budget Refinement Act); the persistence of a significant number of uninsured New Hampshire residents (96,000 in 1999); and increased reliance by the uninsured on Community Health Centers. In this environment, concerned citizens, legislators, and policymakers need information in order to make fact-based decisions and to monitor changes in the market.

This detailed financial and economic analysis of the hospital sector of the State's health care market is the first such effort to provide that information. The recommendations in the *Guidelines for Change* and the issues identified above both helped sharpen the focus and determine the starting point of the project to implement these recommendations. Data availability was another important consideration. The Department of Health and Human Services has collected complete annual audited financial statements from the (nonprofit) community hospitals for years.[1] In addition, the Uniform Hospital Discharge Data Set (UHDDS) and national data sets, such as the American Hospital Association *Annual Survey* and the Health Care Finance Administration's *Medicare Cost Reports*, provided standardized data sources that do not exist to the same extent for other sectors in the health care system.

[1] For profit entities are not required to make their annual audited financial statements available to the public. New Hampshire's two for profit hospitals, similar to others like them around the country, have their financial performance consolidated in the statements of a large national corporate entity.

Acute Care Hospitals



As the largest component in the health care sector (in terms of gross revenue, services provided, employment and ownership of integrated health care systems) and as providers with non-profit missions, hospitals are inevitably drawn into related debates concerning some of the most sensitive and pressing issues in the health care system: the provision of services to the uninsured and the poor, public accountability and the impact and utility of market reform on the heath care system.

In 1998, the Department of Health and Human Services, the Department of Insurance, the Department of Justice and the Governor's Office created an Interagency Workgroup to jointly consider major health care issues and develop coordinated policies. The Workgroup is interested in an effective health care delivery system that ensures high quality, affordable health care for all New Hampshire citizens. This includes access to insurance coverage, statewide access to health care services for all residents, and adequate distribution of providers in rural and medically underserved areas

For New Hampshire's hospitals, this study represents an examination of financial results over a seven-year period and how they have competed or cooperated within their markets. Their performance within the state and in comparison to hospitals in other New England states and the nation allows the hospitals and their communities to consider the most appropriate responses to a very fluid health care market

Finally, the hospital analysis will serve as an analytical template that the state can apply to other sectors of the health care system.

The Process

The 24 non-profit hospitals were included in the financial analysis (see footnote 1). All 26 hospitals were included in the economic analysis. The map on the previous page includes the name and location of each of New Hampshire's hospitals. [2] For the purposes of this study, rural hospitals are any hospitals that are members of the Rural Health Coalition. [3]

Seven years of audited financial statements (1993-1999)[4] were standardized and analyzed for the non-profit acute care community and teaching hospitals. Data from the financial statements was organized into Excel spreadsheets, standard financial ratios were calculated (profitability, liquidity, solvency) and a cash flow analysis was performed. Preliminary figures were presented to hospital and DHHS staff. Each hospital was then given an opportunity to review their data and to make any necessary revisions. Section II of this report contains the aggregate results of this analysis.

The next step in this process - the economic analysis - defined and described what competition in health care meant in both theoretical and applied terms. The applied definition examined every hospital admission from every zip code in the State. If a hospital had more than three percent of its total admissions from a zip code, then that zip code was considered part of that hospital's service area. This allowed for the identification of the concentration of the market that hospital displayed (that is, the

[2] The map shows the location of each hospital in the State, but it does not show the relationships between them or the alliances they have formed that reach across communities. These relationships have formed and reformed over the past several years and it would have been difficult to depict them on this map.

[3] This does not preclude the DHHS, Office of Rural Health's efforts to define "rural" in New Hampshire. As stated above, the decision was made, in conjunction with the NH Hospital Association, to group the hospitals this way based on their self-designation (i.e., membership in the Rural Health Coalition).

[4] The original study was to have gone up to 1998, however, at the request of the NH Hospital Association, it was expanded to include the 1999 results.

percentage of the total admissions in the service area that went to a specific hospital) and the number of competitors in each service area. The ways that each hospital constructed arrangements with other hospitals (horizontal arrangements) as well as with physicians and other non-hospital providers (vertical arrangements) were then considered. Not only did the analysis permit the examination of competition within the State, it also constructed indices to assess how that competition might change in the future. Section III of this report contains the Executive Summary of this analysis.

In order to present a more complete picture of the context in which the State's hospitals function, a Fact Sheet was developed for release with this report. [5] This Fact Sheet looks at health care expenditures over time in the State. Data from state health expenditure accounts constructed by the Health Care Financing Administration (HCFA) were released in the fall of 2000 and were used to create this Fact Sheet.

Financial Ratio Analysis

Financial ratio analysis is the process whereby the figures contained in an organization's annual audited financial statements are translated into more easily understandable and relevant information. These standard financial ratios have been empirically tested and shown to be of value in identifying problems and predicting business failures. Financial ratios are used to look at an organization's performance over time and to compare that performance to industry averages. [6] In order to discover trends, a minimum of five years worth of data should be analyzed (Cleverley, 1997).

Two of the most commonly used financial ratios to express hospital income are the operating margin and the total margin. Operating margin (the portion of operating revenue remaining after all operating expenses have been paid) reflects the hospital's "core business" or that related to patient care, while total margin (the portion of revenues remaining after all expenses are paid) represents the composite financial health of a hospital over a given time period (Pennsylvania Health Care Cost Containment Council, October 1999). Use of operating margin alone can be wrong and misleading (Cleverley, 1997). Total margin is the "bottom line in describing hospitals' financial status" (Guterman, 2000) because it compares total revenues from patient care and other sources with total expenses of a hospital, which includes all of a hospital's activities.

Margins, however, are considered inadequate measures of financial performance when considered alone and should be supplemented with other indicators of profitability, liquidity, solvency and a cash flow analysis (National Health Policy Forum, March 1999), as demonstrated in Dr. Kane's analysis in this report. In 1998, an expert panel convened by the American Hospital Association recommended such an approach when they proposed a minimum or basic set of indicators to be used to assess hospital financial viability, many of which could be derived from audited financial statements (American Hospital Association, 1998).

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[5] *Health Care Expenditures in New Hampshire* prepared by Boyd Gilman, Center for Health Economics Research, is available on the DHHS website: www.dhhs.state.nh.us or can be obtained by calling (603) 271-5254 or writing the Office of Planning and Research, NH DHHS, 129 Pleasant Street, Concord, NH, 03301.

[6] The Center for Healthcare Industry Performance Studies - known as CHIPS - produces one such set of standards that was utilized in the financial analysis contained in this report.

Economic Analysis

The financial analysis portrays the financial health of individual hospitals and the hospital system. It does not indicate how hospital markets operate, that is, how hospitals compete or cooperate with each other and with non-hospital providers.

Hospital market operation is referred to here as the "economic analysis" or a measure of the competitive nature of hospital markets and the impact that competition has on hospital performance. For example: how many other hospitals does a hospital compete with when it offers services? How concentrated is each hospital's service area (i.e., what percentage of all hospital services does it control within its service area)? Does the level of competition (the number of competitors and market concentration) affect the cost or price of services or the access the poor and uninsured have to care?

When the term "market analysis" is used in conjunction with this report, it is not the type of analysis an organization does to define its niche and advertise or "market" itself to attract new customers. This type of analysis is often part of a hospital's strategic planning exercise. While the information presented in this section of report could be incorporated into such planning activities, the study was not performed with that use in mind.

Nonprofit Health Care Charitable Trusts and Community Benefits

A common misconception about nonprofits is that they cannot make a "profit." Nonprofits can and do make "profits" (however, they are not distributed to investors). In fact, an organization that is not "profitable" may not be able to stay in business. "Profits" (or a "positive margin" or an "excess of revenues over expenses") are required for an organization to be able to meet its mission and to continue to provide quality health care. The total financial requirements of any viable financial organization include funds for growth, new programs, working capital needs and replacement of equipment (Suver et al, 1992). Hospitals that borrow to meet their capital needs must be creditworthy; the better their financial status, the lower the cost of borrowing.

Public accountability distinguishes nonprofits from for-profit or proprietary firms that report to their shareholders. In return for the special tax-exempt status that nonprofits enjoy, the community has certain expectations. New Hampshire, like other states, has passed "community benefit" legislation that requires all health care charitable trusts to account for how they meet their mission (see **TAB 6** for a copy of that legislation passed in 1999). New Hampshire's law requires that a health care charitable trust perform a community needs assessment (every three years); develop a community benefits plan; and submit that plan on an annual basis (with an evaluation) to the Office of the Attorney General.

Communities and states are not the only ones examining nonprofits and community benefits. Leading health policy experts are calling for better measurement and more formal accountability (for example, through the establishment of benchmarks) of the community benefits delivered by nonprofit hospitals as a means of improving public policy (Nicholson et al, 2000 and Reinhardt, 2000).

An Outline of This Report

This report (**Section I**) begins with a statement on the importance of strong and responsive community hospitals to New Hampshire's health care delivery system. It offers an overview of how hospitals evolved to the point they are today and what financial pressures they face and the steps they are taking to deal with those pressures. A brief summary of the financial and economic analyses (which follow this section) is also included. Finally, this section concludes with recommendations for action by both the public and private sectors to maintain and monitor the mission of New Hampshire's community and teaching hospitals.

The next section of this report (**Section II**) contains the discussion of the aggregate financial analysis of New Hampshire's hospitals and how they compare to their counterparts in the State, the region and the United States. Standard financial ratios are defined and a cash flow analysis over the study period is provided. Suggestions of how New Hampshire might assess community benefits are included, as well as a separate discussion on how rural hospitals performed in relation to the rest of the hospitals in the State.

The last section of this report (**Section III**) represents the Executive Summary of the aggregate economic analysis of the New Hampshire hospital market. The full report - which includes details such as the methodology used and a discussion on the market and health care - can be found on the Department of Health and Human Services website www.dhhs.state.nh.us . The Executive Summary provides the key findings, together with selected charts and tables from the full report.