

# Making Financial Information Useful for Public Policy

Presentation to Green Mountain Care Board

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# Background

- Professor of Health Policy and Management, Emerita at Harvard T.H. Chan School of Public Health; taught financial accounting, payment, strategy courses at graduate and executive levels
- MBA & DBA from Harvard Business School
- Currently on Board of UMass Memorial Health System; Chair of the Finance Committee
- Served as Commissioner on the Medicare Payment Advisory Commission for two terms and Massachusetts Office of the Attorney General Task Force on Community Benefit and a Special Commission on the Health Care Payment System for the state Health and Human Services agency
- 40+ years of experience as consultant on health care financial and strategic issues, served on six other health care-related boards

# Best Use for Financial Analysis in Hospital Rate-Control:

- Assessing the financial implications of rate decisions
- Understanding the financial impact of strategic choices made by health systems
- Identifying financially advantaged/wealthy vs. sustainable vs. distressed systems/hospitals

# Audited Financial Statements NOT Useful for:

- Determining “efficiency” of a hospital or health system
- Describing the profitability of specific service lines/businesses e.g. surgery vs medicine
- Providing the one metric that measures financial health

# Some Challenges to Making Audited Financial Data Useful for Public Policymakers

- Financial Literacy (of analysts and audience)
- Entities Involved (hospital vs system), number of entities
- Availability and Timeliness of Audited Financial Statement
- Focus of Analysis (Metrics, Groupings, Standards for Judgment)
- Standardized vs Custom Analysis

# 12 Financial Metrics Capture Basic Financial Picture of Health System

Financial Metric	Standardization
Total Margin	Exclude Unrealized Gains/Losses on financial assets
Operating Margin	Exclude investment returns of all types, as well as gains on sales of nonfinancial assets and other one-time, non-recurring transactions
Days Cash on Hand, All unrestricted Sources	Omit donor restricted and “trustee-held” (contractually or otherwise legally obligated financial assets, such as debt service and self-insurance reserves)
Cash and Investments in \$, all unrestricted sources	See above
Long-term debt/total capitalization	Includes capital leases; may want to start including operating leases as well
Pension-adjusted LTD/Total Capitalization	See Above
Cash and Investments/LTD	See Above definitions for LTD and Cash and Investments
Debt Service Coverage	Using current not max annual DSC
Average Age of Plant	Need to acknowledge when a significant portion of capital assets are leased/not owned by system
Capital Expenditure/Depreciation expense	Ideally cumulative over 5 – 7 years; CapEx derived from Statement of Cash Flows
Government Operating Subsidy/Total Operating Revenue	Include net MSF, indigent care pool, special subsidies
Uncompensated Care Burden	Free care at cost; implicit price concessions when reported

# Standards of Comparison

- “Peer Group” distribution (AMC, Community Hospital, etc.)
- Expert Judgment (e.g., advantaged, adequate, red flag, weak)
- Rating Agency Medians for Investment Grade Bond Rating
- State-wide average

# One Health System with 3 Hospitals Accounts for Roughly 70% of Vermont Acute Hospital Activity

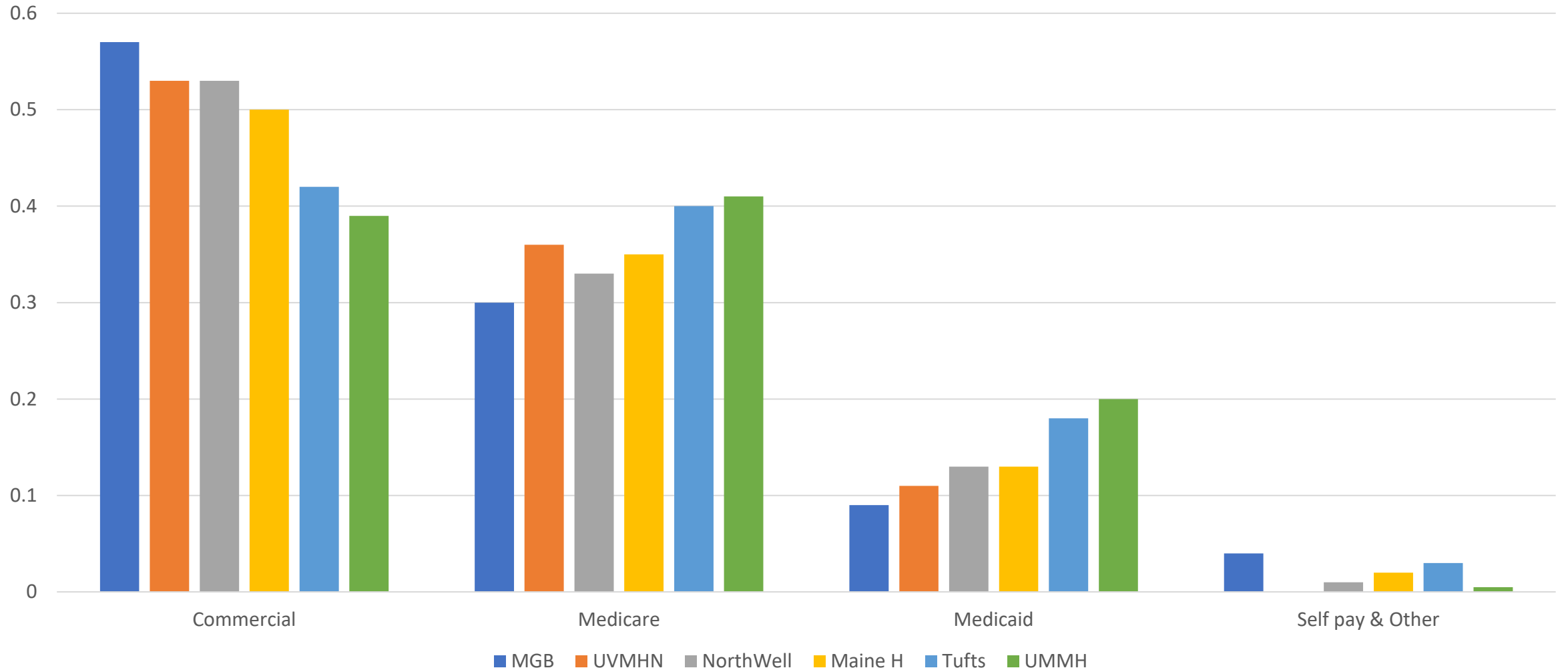
	% Beds	% GPSR	% Discharges	% Patient Days
UVMHC	48%	56%	47%	56%
Porter	3%	3%	4%	2%
Central Vt	19%	14%	17%	14%
Total UVMHM	69%	72%	68%	73%
Rutland Regional	15%	11%	13%	14%
Seven Others	16%	17%	19%	14%



# Peer Group of Academic Medical Centers with Multiple Community Hospitals (convenience sample)

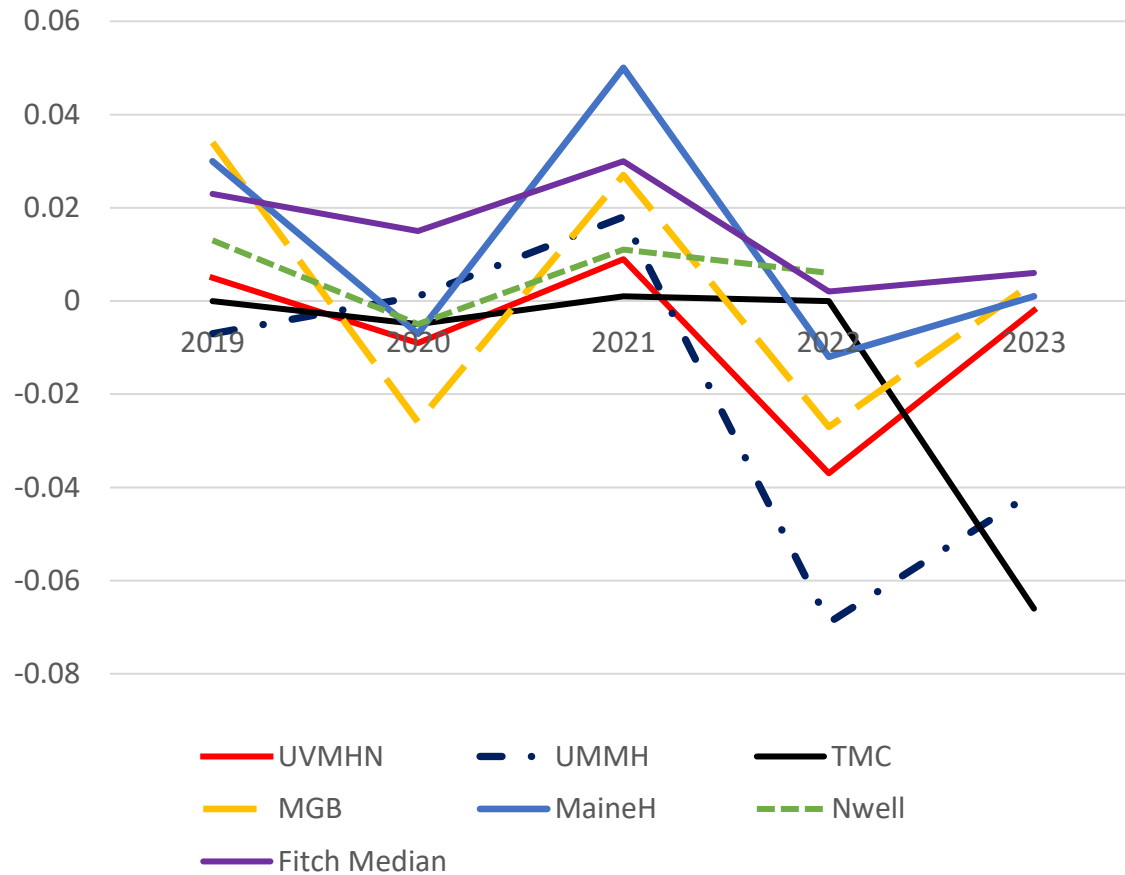
- Umass Health
- MGB
- Tufts Med
- Maine Health
- Northwell
- UVMHN

# Payer Mix as % of NPSR (2022)

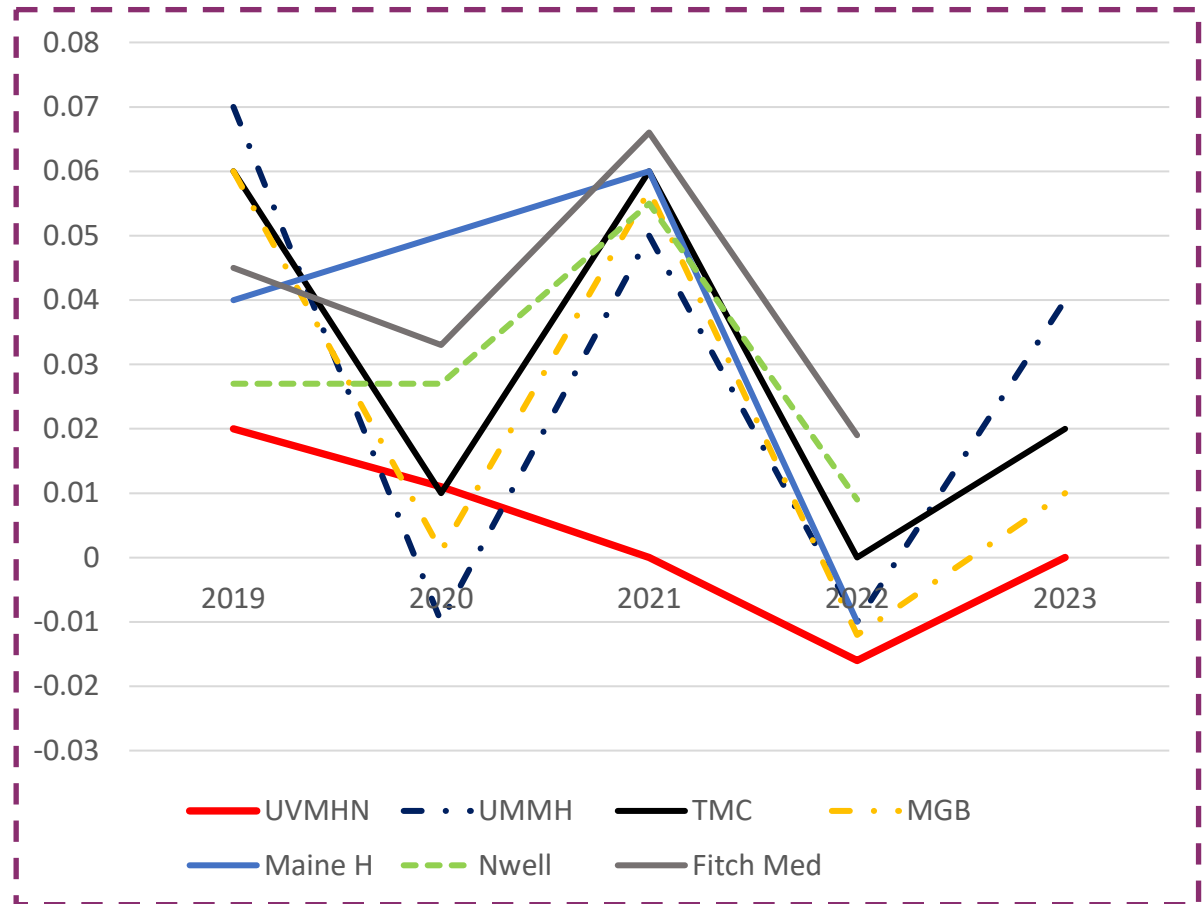


# Profitability

## Operating Margins Excluding Asset Sales

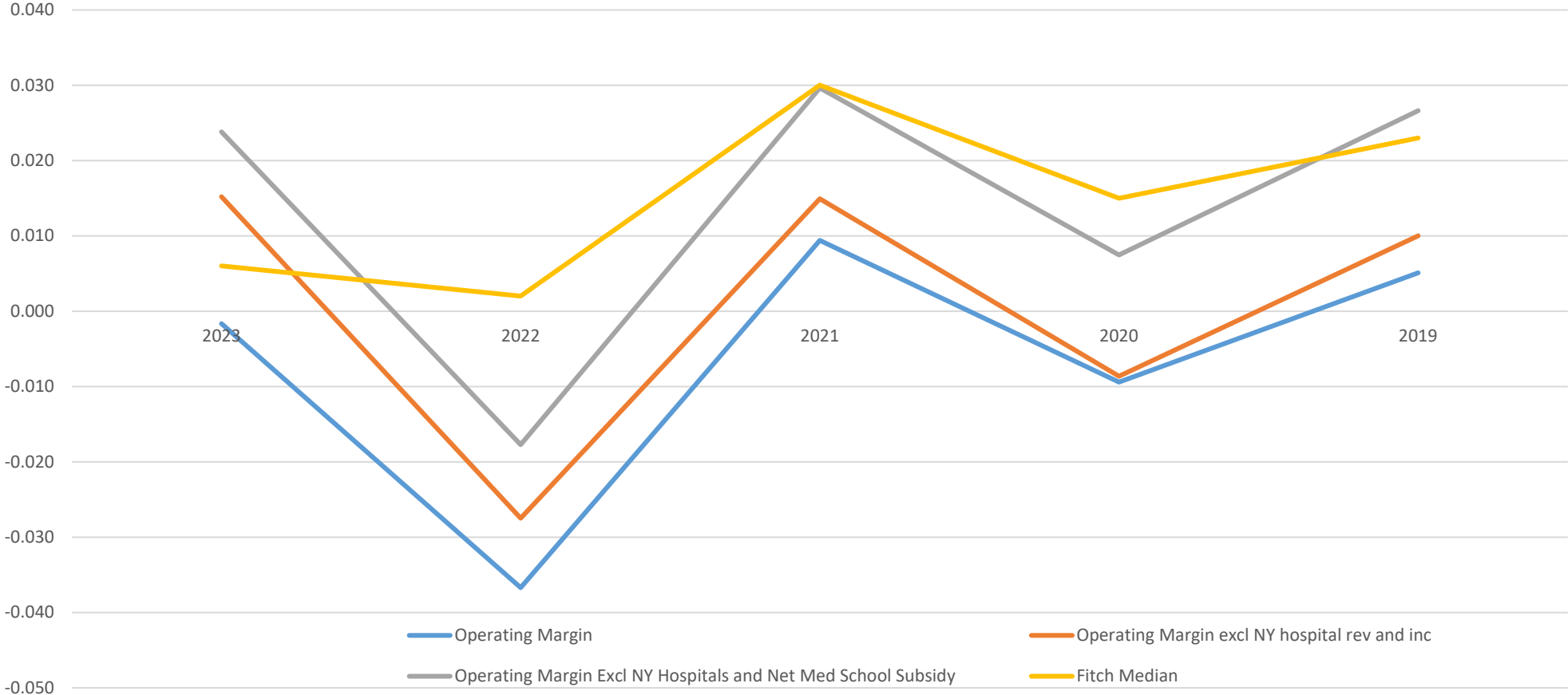


## Total Margins Excluding Unrealized Gains/losses



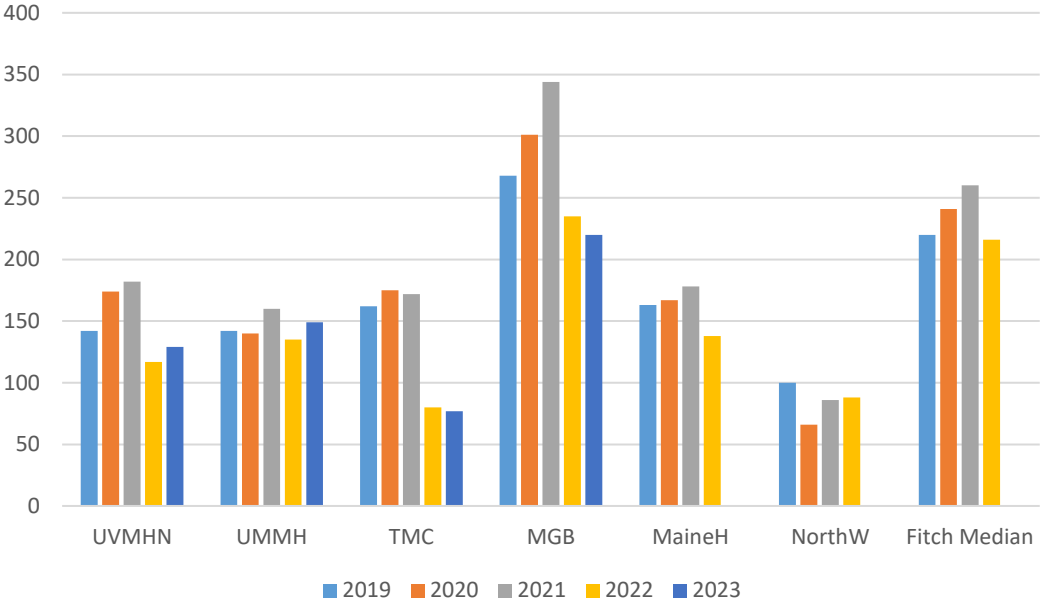
Removed Tufts (-17%) 2022; Maine Health 2023 9 mos

# Impact of New York Hospitals and UVM Med School Net Subsidies on UVMHN Operating Margin

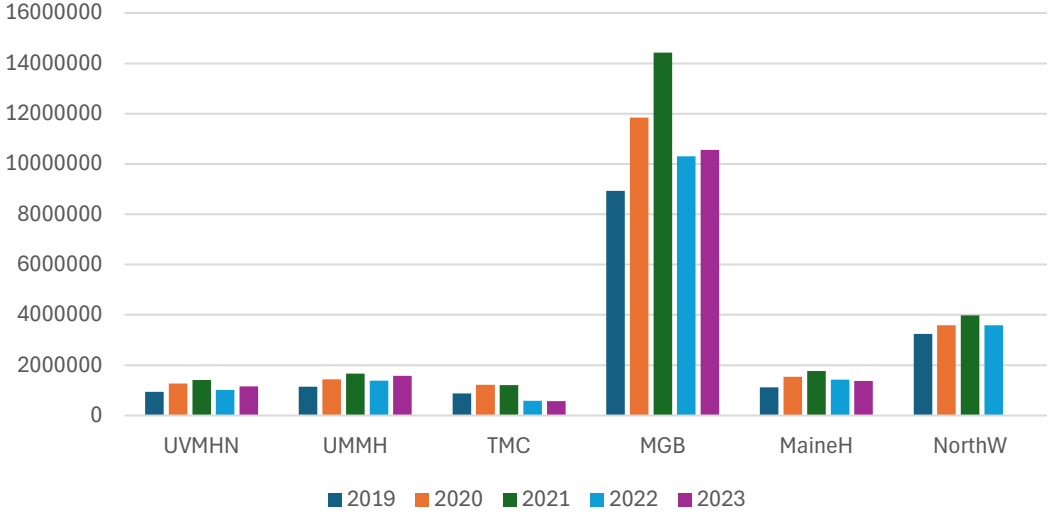


# Liquidity

Days Cash on Hand, All Sources, Excl MMAA and Def SS Tax

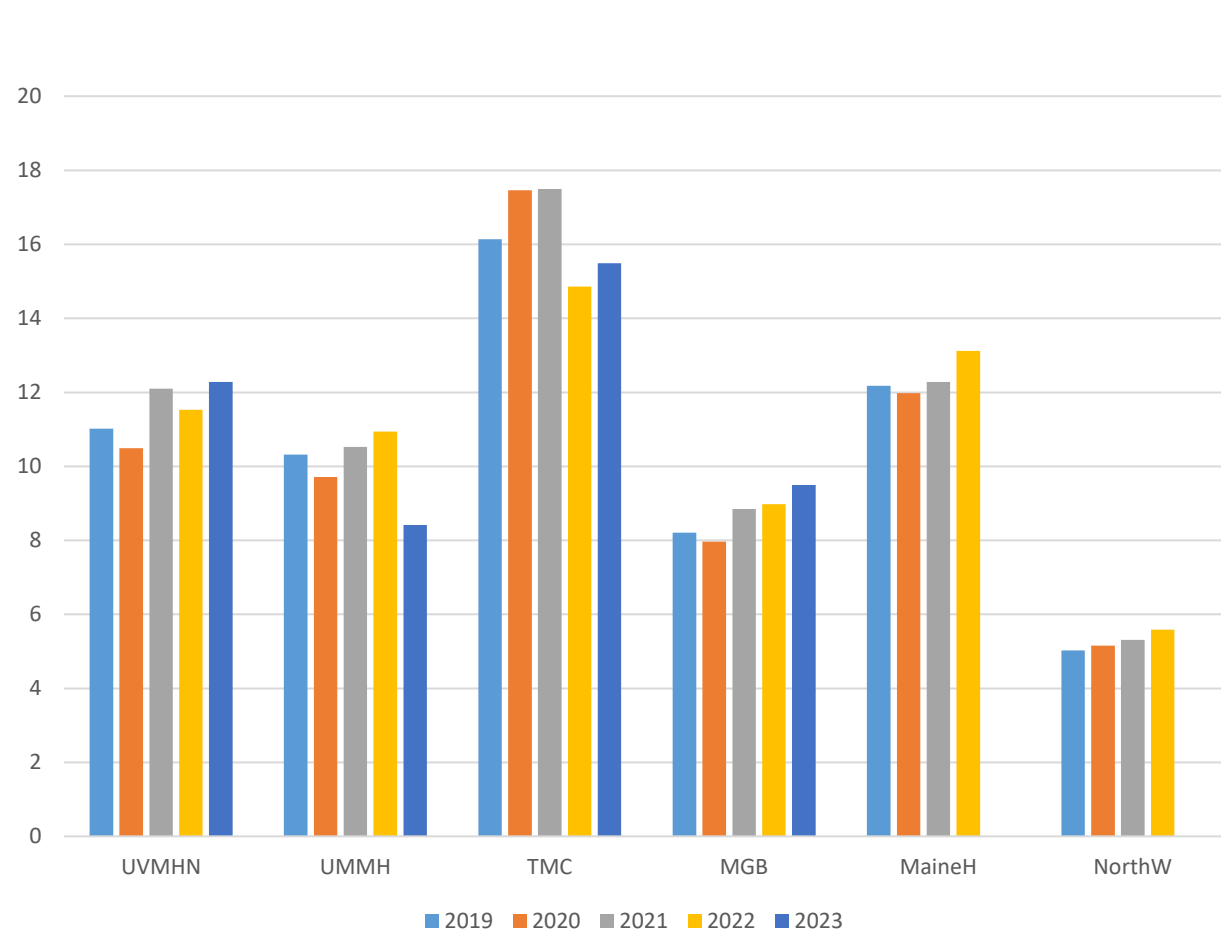


Unrestricted Cash and Investments Excl MAAPP and Def SS Tax, \$000

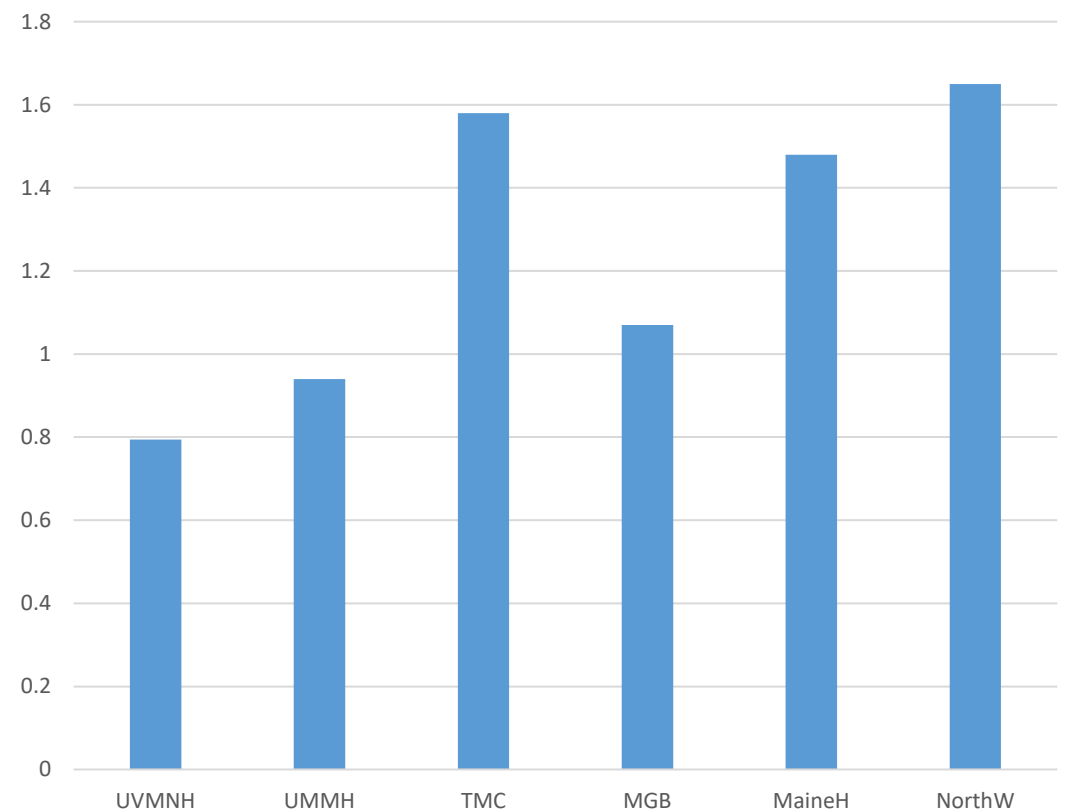


# Adequacy of Capital Spending

## Average Age of Plant



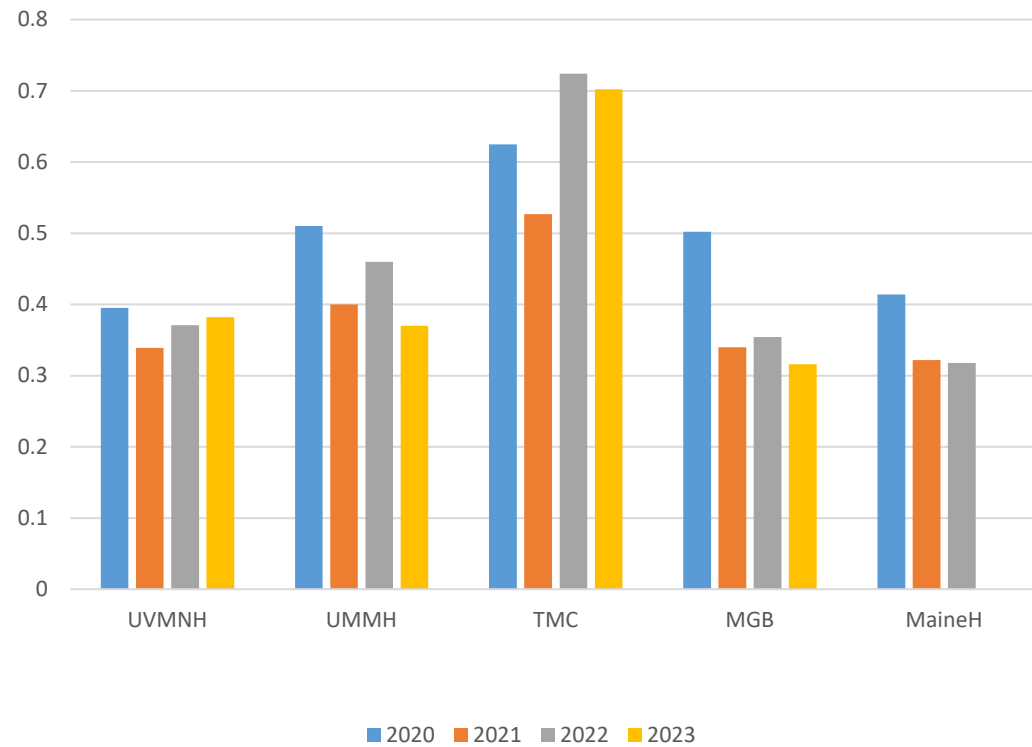
## Cumulative Cap Ex/Depreciation 5 yrs



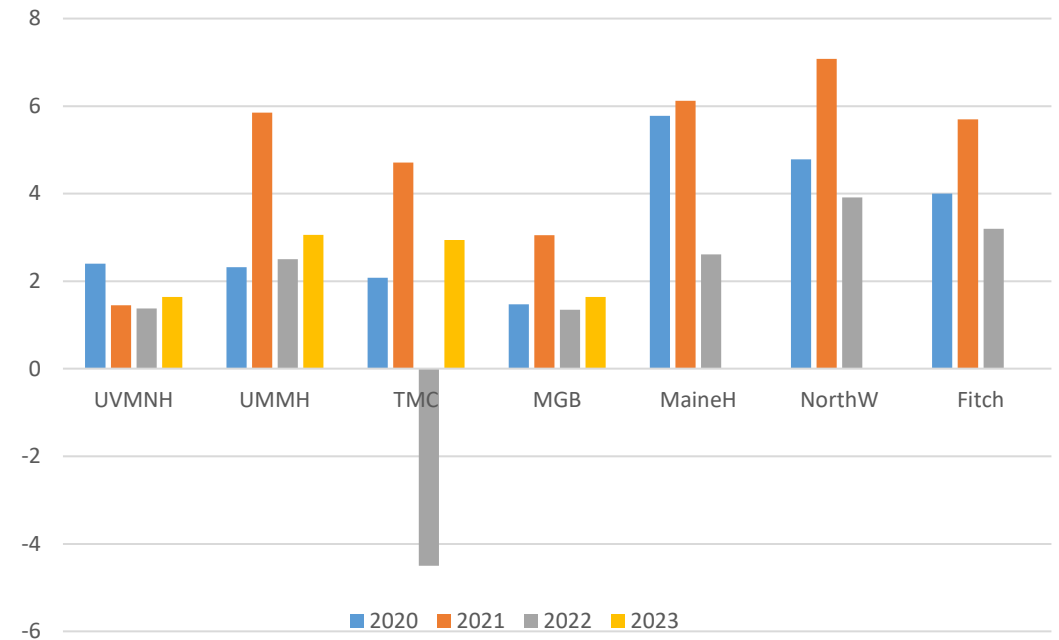
Maine H 2019-2022; NorthWell 2018-2022

# Solvency

## Pension, Lease\_adj LTD/Total Capitalization



## Debt Service Coverage



# UVM Medical Center Entity

	2023	2022	2021	2020	2019	
<b>Profitability:</b>						
Total Margin excl unreal gain/loss	0.033	-0.018	-0.012	-0.006	0.023	
Operating Margin	0.031	-0.012	0.023	-0.003	0.022	
Operating Margin before Net UVM Pay	0.042	0.000	0.041	0.017	0.043	
						<b>Cumulative:</b>
Transfers to other affiliates	-2285	-30666	-610	-50859	-8756	-93176

**As of 2023, UVM Medical Center had short term loans to affiliates of \$87M**



# Transfers of Equity (excludes loans to affiliates) within UVMHN

Intra-UVMHN Transfers	2023	2022	2021	2020	2019
UVMHC	-2285	-30666	-610	-50859	-8754
CVMC	-1268	500	56	1468	7631
CVPH	-441	-491	-573	-5	4537
ECH	0	0	925	73	21
UMMHN	-101356	73950	-870	-27798	-42189
Obligated Group Eliminations	100430	-14033	372	76087	48249
PMC	1268	-300	-28	300	341
Alice Hyde	409	-425	0	106	480
Home and Hospice	500	500	500	800	860
Other entities	2526	8349	14698	13253	-3131
Eliminations	369	-37506	-14985	-4846	-8044
sum of "transfers & other"	152	-122	-516	8579	-21

# Takeaways

- UVMHN survived one of the worst 3-year periods of operating results in industry history with financial results similar to other major academic/community systems in Northeast (better than some, worse than others)
- UVMHN made strategic choices that reduced its profitability and liquidity (medical school net subsidies, financially supporting New York hospitals) (mostly financed by UVMMC)
- Regarding capital expenditures, UVMHN appears to be underinvesting in recent years, but average age of plant is within Fitch median range