

FOR THE WISCONSIN OFFICE OF RURAL HEALTH



The Financial Effects of Wisconsin Critical Access Hospital Conversion

Rural Wisconsin Health Cooperative



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EXECUTIVE SUMMARY

Critical Access Hospital (CAH) designation was introduced through the Medicare Rural Hospital Flexibility Program (Flex Program) as part of the Balanced Budget Act (BBA) of 1997. The first Wisconsin CAH hospitals were certified in 1999. This study is the fifth since the CAH program was implemented. As with the prior Wisconsin CAH study financial performance studies completed in 2003, 2005, 2007, and 2009, the purpose of this study is to analyze the financial condition of Wisconsin's CAHs. There have been many changes in the healthcare industry since the last study was completed in 2009. Major health care legislation was passed. The country continues to struggle with high unemployment and protracted economic weakness. Federal and State budget deficits are jeopardizing adequate government program provider payments. Access to capital for buildings, equipment and technology continues to be an issue for hospitals.

For Wisconsin hospitals this study shows that:

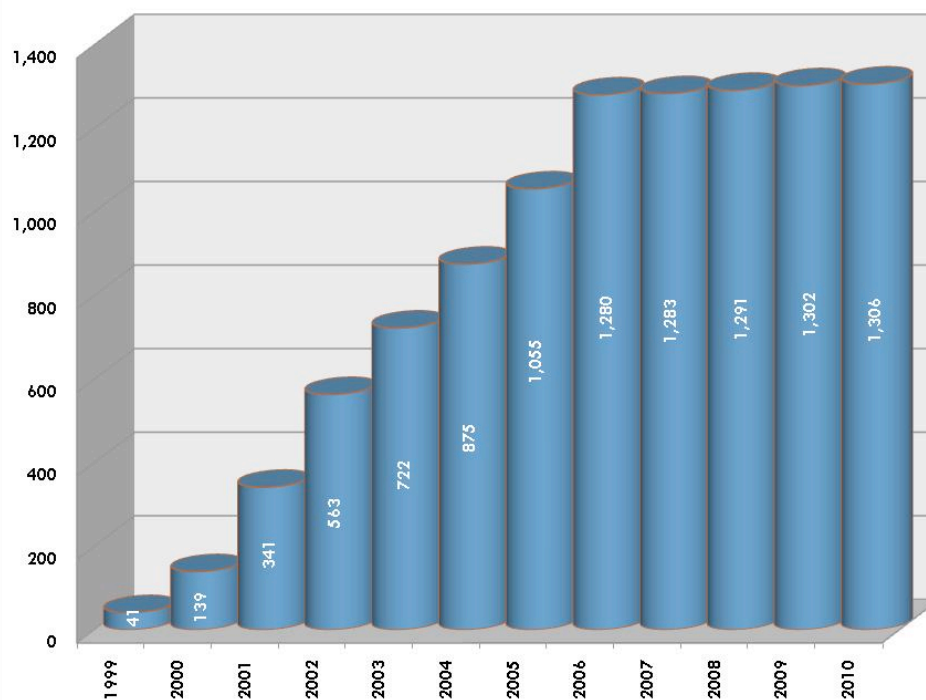
- The average Total Margin for CAHs was about 4.3% in 2008, 4.9% in 2009, and 5.6% in 2010 while the average Total Margin for PPS hospitals was 4.4% in 2008, 8.1% in 2009, and 9.1% in 2010.
- CAHs continue to experience lower Operating Margins than PPS hospitals. 2010 Operating Margins remained about the same as 2009 for both groups.
- Average Age of Plant increased for both groups in 2009 and 2010. CAH Average Age of Plant is still higher than PPS hospitals.
- Net Days in Accounts Receivable declined for both CAHs and PPS hospitals in 2009. This ratio remained about the same in 2010 for both groups.
- Overall strength as measured by the Financial Strength Index increased in 2009 and 2010 for both CAHs and PPS hospitals. The improvement in Financial Strength was higher for PPS hospitals for both years than for CAHs.
- There have been changes in services provided for both CAH and PPS hospitals. The reason for these changes may be related to financial considerations.
- Several key utilization statistics such as inpatient days, surgical operations, births, and emergency visits showed less growth or more rapid decline since 2000 for CAHs than experienced by PPS hospitals.
- CAH's outpatient revenue as a % of total revenue has increased since 2000 and CAH's have higher outpatient % revenue to total revenue than PPS hospitals.
- The 2010 US census result shows Wisconsin population increased by about 6% from 2000. Many rural counties showed small increases or in some cases, decreased population.
- The % of Wisconsin Medicare beneficiaries covered by Medicare Advantage plans continues to rise.
- The % of Uncompensated Care decreased slightly in 2010 for both groups.

- It is important to note that the annual Wisconsin Hospital Fiscal Survey does not include nursing home financial information. More CAH's in Wisconsin have nursing homes than do PPS facilities (see Changes in Services). Nursing homes typically generate lower contribution margins than hospital operations. Therefore, the study probably overstates the strength of CAH facilities compared to the PPS group.
- Some 2011 Wisconsin hospital surveys indicate weakening financial performance, especially for CAH's. This trend, however, cannot be confirmed until additional historical data is reported and analyzed.

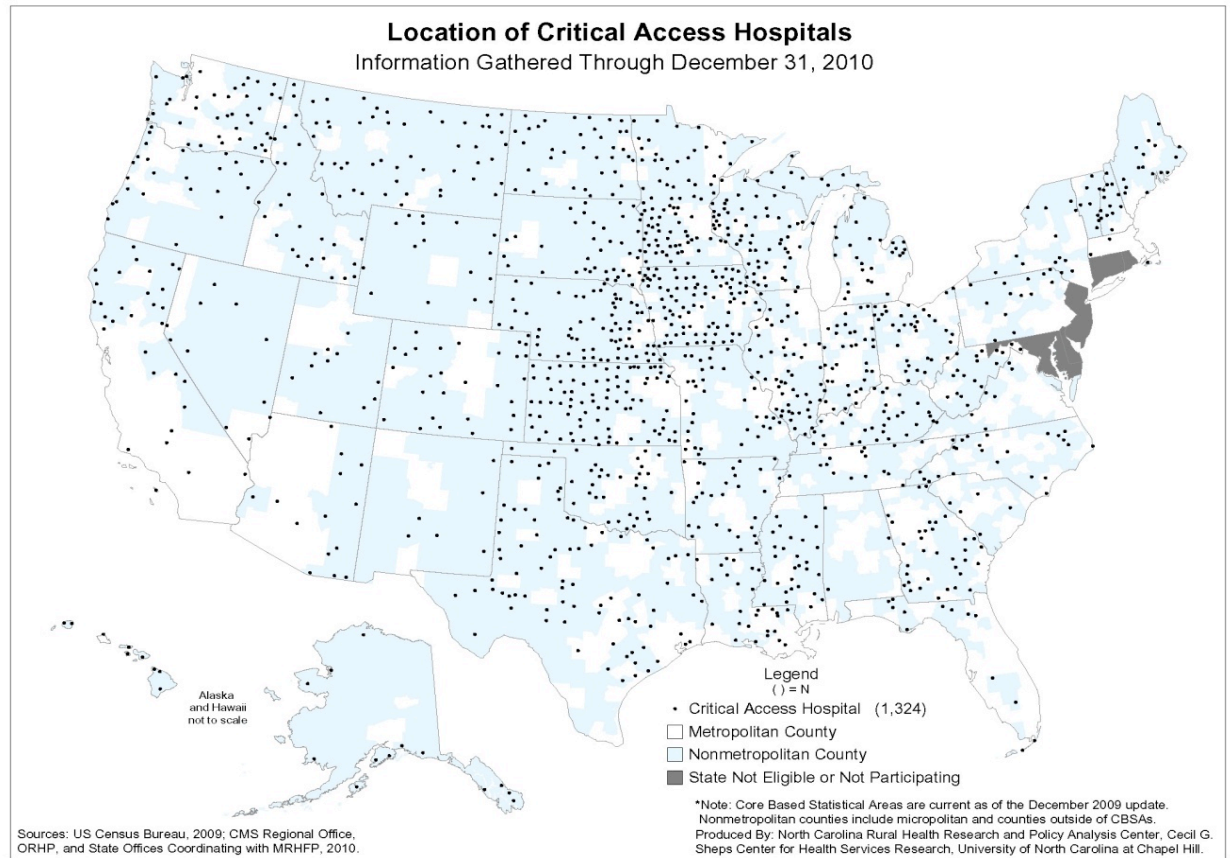
The number of CAHs nationally has grown steadily over the last ten years. As of June 2010, there were 1,306 CAHs in the United States (see following graph). Most CAHs are located geographically in the central part of the U.S. (see following map). The increase in CAHs is in part due to a series of legislative changes that made conversion to CAH status possible for more facilities to consider and, therefore, expanded the services that qualify for cost-based reimbursement. Prior to 2006, hospitals could convert to CAH status if they were (1) 35 miles by primary road or 15 miles by secondary road from the nearest hospital, or (2) their state waived the distance requirement by declaring the hospital a "necessary provider." Starting in 2006, states can no longer waive the distance requirement. While many existing CAHs do not meet the distance test, they are grandfathered into the program. Among small rural hospitals that have not converted, most do not meet the distance requirement. Therefore, the number of CAHs since 2006 has remained fairly constant.

Number of Critical Access Hospitals in the U.S., 1999-2010

Number of U.S. Critical Access Hospitals, 1999-2010



Location of Critical Access Hospitals



Currently, Wisconsin has 59 CAHs which means roughly 40% of all Wisconsin facilities were CAHs. Critical Access Hospitals are located in 43 of Wisconsin's 72 counties (see following map). Two facilities did not exist prior to 2005 and were not included in the study due to lack of historical financial data. Of the 57 facilities in the study, 17 were certified in 1999, 2000, or 2001 (see Table 1).

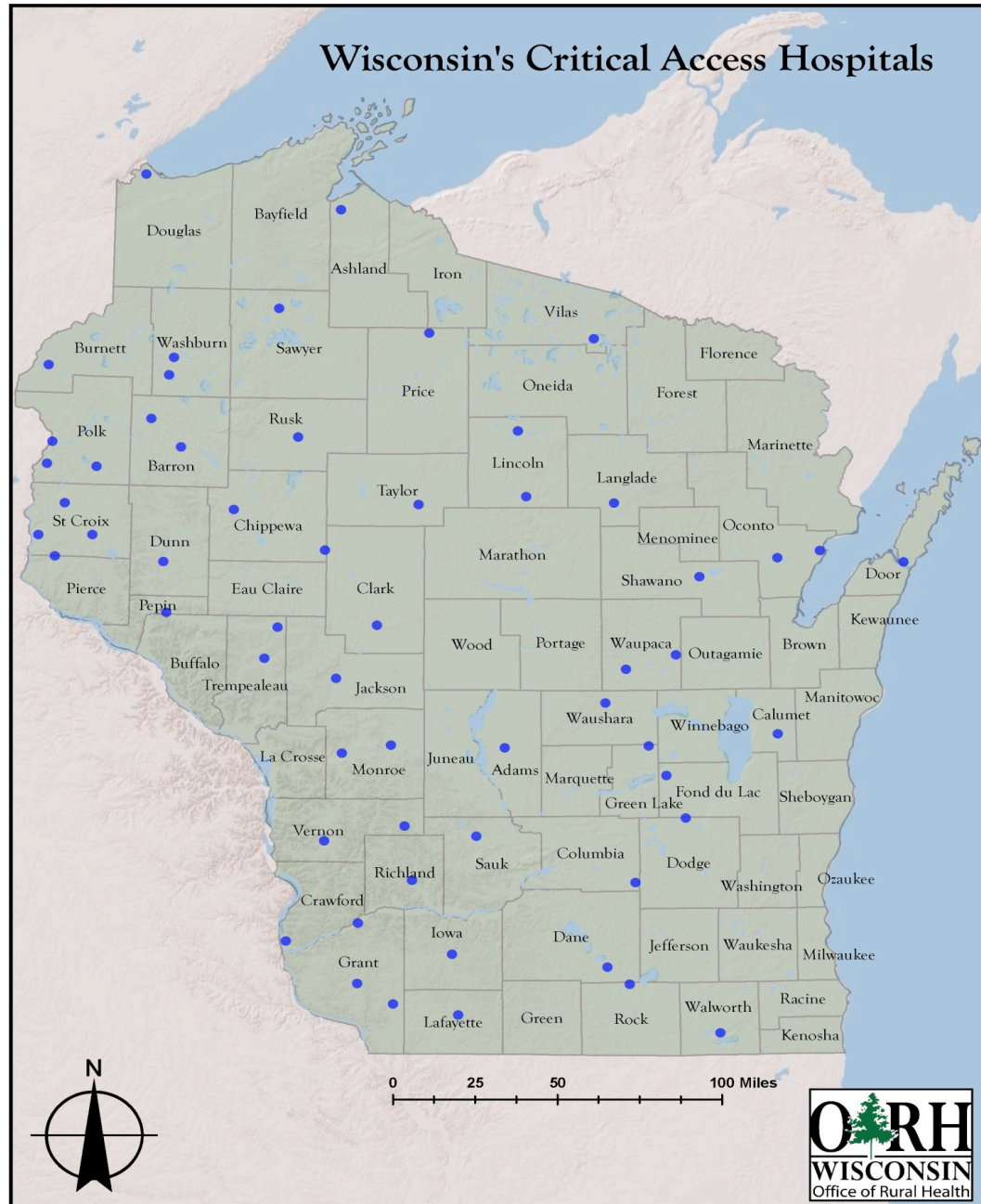


Table 1: Wisconsin CAHs by Year of Certification

YEAR	Certified	TOTAL FOR STUDY
1999	2	2
2000	6	6
2001	9	9
2002	8	8
2003	6	6
2004	17	17
2005	9	7
2006	1	1
2007	1	1
2008	0	0
2009	0	0
2010	0	0
Total	59	57

- The facilities that converted to CAH status early were generally smaller and not as financially strong as the later converters. The largest group (31 facilities) received critical access certification during 2002, 2003, and 2004. The remaining nine study facilities converted in 2005, 2006, and 2007.

Financial and services data were analyzed for eleven years (from 2000 through 2010). The 57 study facilities are categorized as CAHs. Table 2 shows if the study facility was paid as a CAH or under the Medicare PPS. It also shows if the facility converted during its fiscal year (PPS/CAH).

Table 2: Study Hospitals by Year and Medicare Payment Type

YEAR	PPS	PPS/CAH	CAH	ALL STUDY
2000	50	5	2	57
2001	42	7	8	57
2002	34	6	17	57
2003	29	3	25	57
2004	16	12	29	57
2005	11	14	32	57
2006	1	6	50	57
2007	1	0	56	57
2008	0	0	57	57
2009	0	0	57	57
2010	0	0	57	57

- Most charts graph CAH study facilities, all other hospitals, and both groups combined. Psychiatric, Children's, Veterans, and Rehabilitation hospitals were excluded from the study.
- The source of most of the study data was the Wisconsin Hospital Fiscal Survey and the Wisconsin Annual Survey of Hospitals. These surveys are completed annually by all Wisconsin hospitals and returned to the Wisconsin Hospital Association (WHA) Information Center.
- The Financial Strength Index (FSI) is a ratio that combines several key performance indicators (see further discussion in the Financial Performance section of this study). This ratio declined in 2008 but increased for both groups in 2009 and 2010. The increase in FSI was due to increases in both Total Margins and Days Cash on Hand. The increase in these ratios offset the negative effect on FSI of the increase in the Average Age of Plant ratio (see below). The FSI ratio shows both groups in the "Good" range in the FSI Rating Guide (see Table 6).
- After a decrease in the Average Age of Plant in 2008, both CAHs and PPS facilities experienced increases in this ratio in both 2009 and 2010 (see further discussion in the Average Age of Plant Ratio section.)
- The analysis indicates decreases in some services provided by CAHs. This may indicate that hospital boards and management have decided to drop services that have a negative financial impact on the overall organization. See the "Changes in Services" section for further discussion of this issue.

INTRODUCTION

As previously mentioned, the purpose of this study is to report on the financial impact of Wisconsin hospitals designated as CAHs. Similar reports were conducted in 2003, 2005, 2007 and 2009.

As of August, 2011, Wisconsin had 59 CAH facilities. The first Wisconsin hospital received CAH designation on October 1, 1999. As previously mentioned, Table 2 shows when Wisconsin hospitals received CAH status and the number of facilities included in this update.

This study primarily uses the information from the Wisconsin Hospital Fiscal Survey and the Annual Survey of Hospitals. Both of these surveys are submitted annually to the WHA Information Center. The information is reviewed for accuracy. The Hospital Fiscal Survey is designed to closely follow the hospital's audited financial statements. For these reasons, the source for most of the study data is the Fiscal and Annual Survey. It is important to note, however, that the annual Wisconsin Hospital Fiscal Survey does not include nursing home financial information. More CAHs in Wisconsin have nursing homes than do PPS facilities (see Changes in Services). Nursing homes typically generate lower contribution margins than hospital operations. Therefore, the study probably overstates the strength of CAH facilities compared to the PPS group. The years included in this study are from 2000 through 2010. Financial ratios were calculated and are shown in graphs to provide the user with a visual aid to measure trends.

REIMBURSEMENT METHODOLOGIES

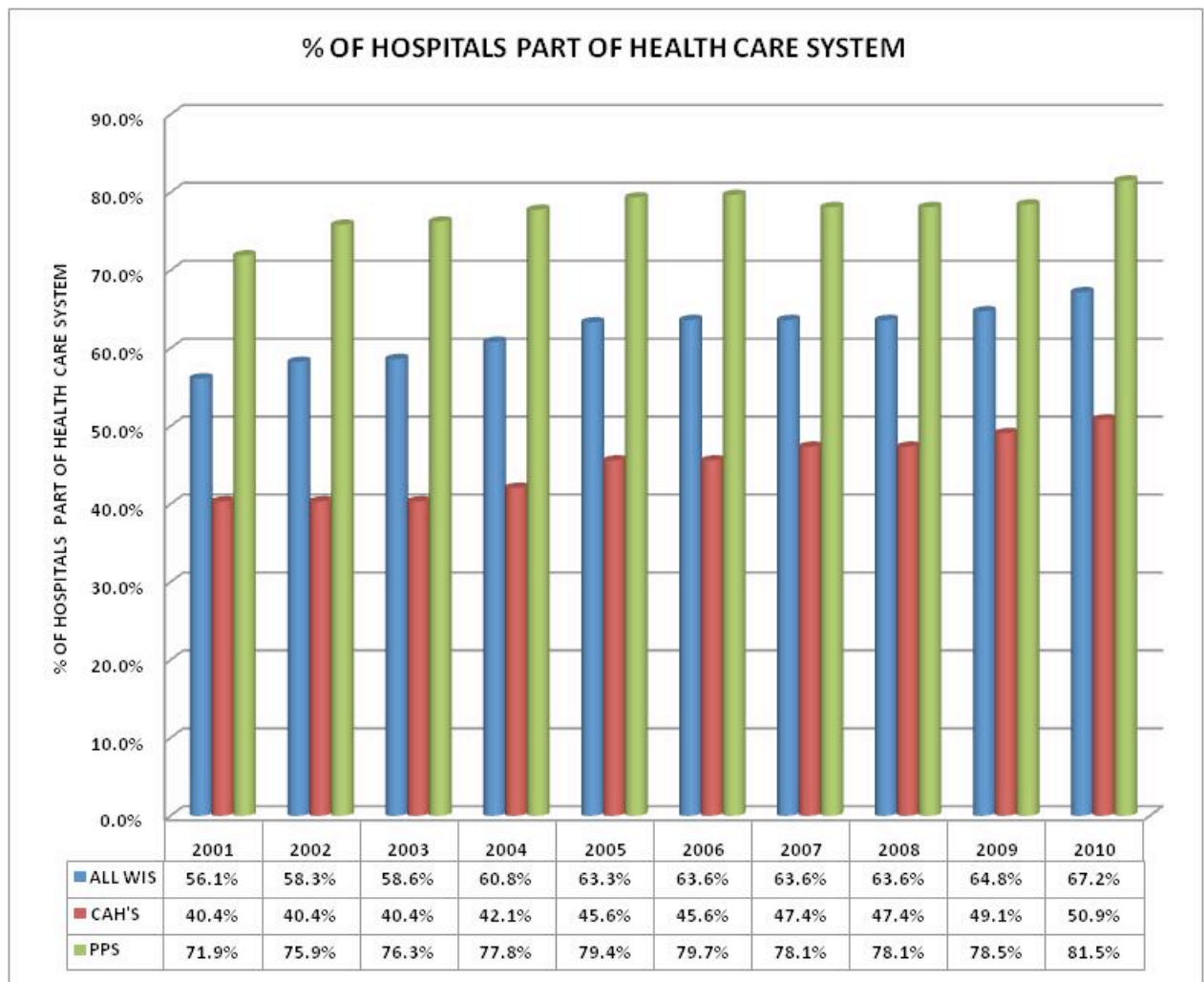
CAH Medicare reimbursement is generally the same as presented in prior studies. Under PPS, inpatient reimbursement was based on diagnosis related groups (DRGs). Swing bed reimbursement was based on a combination of skilled nursing facility per diems for the nursing care and the Medicare program ancillary costs until July 1, 2001. At that time, swing bed reimbursement became based on the prospective resource utilization group (RUG) methodology. Prior to August 1, 2000, outpatient reimbursement was based on a combination of costs and fee schedules. Outpatient reimbursement is now based on ambulatory payment categories (APCs) and fee schedules. CAHs are paid costs for acute care, swing bed and outpatient services. Cost reporting methodology for CAHs splits nursing care costs between acute and swing bed services based on patient days. The resulting nursing cost per diems are equal. The per diem is multiplied by Medicare program acute and swing bed days. A decrease in acute or swing bed patient days will increase the cost per diem and increase Medicare payments. For CAH cost reports beginning on or after January 1, 2004, there is a 1% add-on to allowable Medicare costs, making Medicare CAH reimbursement 101% of allowable costs.

The Wisconsin Medical Assistance Program (Medicaid) generally reimburses CAHs based on costs. Although cost-based payment is usually an improvement over the prospective system that the Wisconsin program uses for other hospitals, CAH Medicaid cost reimbursement was recently amended. Medicaid funding for CAHs has been changed so retrospective cost settlement is no longer assured. The 2011 Wisconsin Medicaid Inpatient State Plan states CAHs will be paid the lesser of a prospectively determined cost per discharge rate or charges. The discharge rate will be inflated to the current rate year by applying the “Hospital and Related Healthcare Costs Index” published by Global Insight. The prospective cost based rate will not be subject to an annual Medicaid cost settlement.

Wisconsin also recently implemented a new 1.4 percent assessment on hospitals’ and ambulatory surgical centers’ gross revenue. Because Medicaid funding is a joint Federal and State program, this measure is expected to increase the state’s Medicaid reimbursement by \$300 million a year. Most of the revenues will be returned to the hospitals, but some of the revenue will be used to expand health coverage to low-income, childless adults. Most states have already implemented a similar provider assessment.

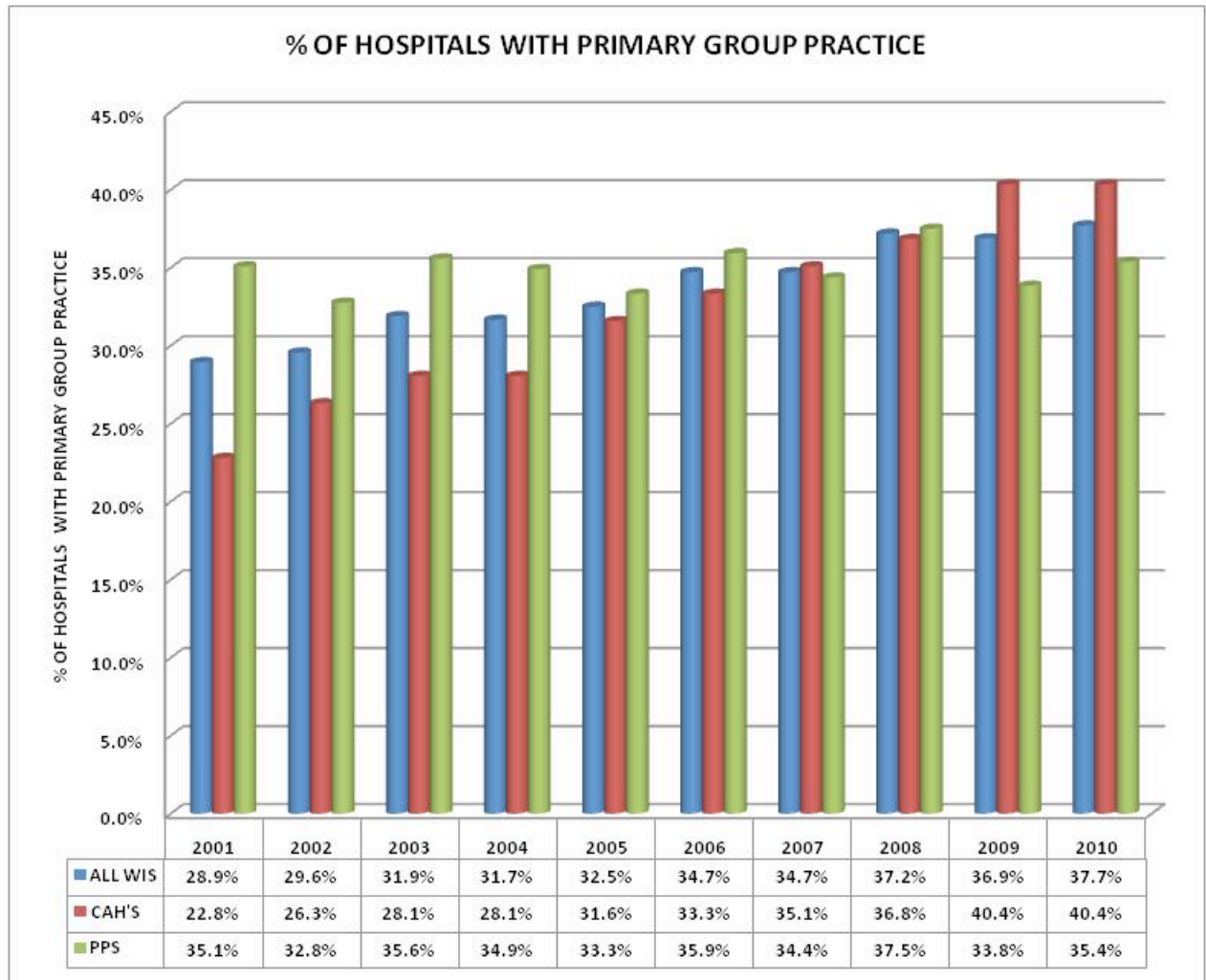
HOSPITAL ORGANIZATION CHANGES

How have Wisconsin hospitals’ organizational structure changed in the last decade? The Wisconsin Annual Survey collects data on whether the hospital is part of a health care system. The following chart shows what percent of Wisconsin CAHs, PPS facilities and both groups combined belong to a health care system.



The chart indicates about 67% of Wisconsin hospitals belonged to a health care system in 2010. This is about 11% higher than in 2001. Over 81% of PPS hospitals in 2010 belonged to a system while only about 50% of CAHs are part of a group. Both groups showed about a 10% increase since 2001.

Another Annual Survey question examines the relationship of Wisconsin hospitals with primary group practices. The survey response to whether or not the hospital owns or operates a primary group practice is graphed in the following chart.



The chart shows that in 2001, the % of CAHs who owned or operated a primary group practice was under 23% while the % for PPS facilities was about 35%. In 2010, a higher % of CAHs (40.4%) own or operate a primary group practice than PPS hospitals (35.4%). The % of hospitals with primary group practices for both groups combined has increased from 28.9% to 37.7% in 2010. One reason CAHs have a higher % of primary group practices is physician reimbursement concerns. Physicians with large Medicare populations are more likely to want to move to hospital-employed positions.

FINANCIAL PERFORMANCE ANALYSIS

As with the prior studies, ratio analysis will be used to evaluate financial performance. A discussion of key ratios selected for this project follows.

Table 3: Financial Ratios and Description

RATIO	DESCRIPTION
Days in Accounts Receivable (net)	This ratio measures the average number of days in the collection period. A larger number of days represent cash that is unavailable for use in operations.
Days Cash on Hand	The number of days of expenses that the hospital can currently cover with its available cash.
Operating Margin	This ratio defines the % of operating income to total operating revenue.
Total Margin	This ratio evaluates the overall profitability of the hospital using both operating surplus (loss) and non-operating surplus (loss).
Average Age of Plant	Age of plant is the average age of property, plant and equipment owned by the hospital.
Deduction Ratio	The deduction percentage measures the proportion of total patient charges that are given up as discounts and allowances.
Financial Strength Index	Composite of four components of entity's financial condition that reflects an organization's overall financial condition.

Table 4 describes how each financial ratio is calculated.

Table 4: Financial Ratio Calculation

RATIO	CALCULATION
Days in Accounts Receivable (net)	Net accounts receivable/Net patient revenue per day
Days Cash on Hand	Cash/(Operating expenses less depreciation/365)
Operating Margin	Total operating revenue-Total operating expenses/Total Operating revenue
Total Margin	Excess of revenue over expenses/Total revenue
Average Age of Plant	Accumulated depreciation/Depreciation expense
Deduction Ratio	Total patient revenue-net patient revenue/Total patient revenue
Financial Strength Index	See discussion below

The FSI is a financial measure that reflects an organization's overall financial condition. The FSI encompasses four major components of an entity's financial condition: liquidity, profitability, capital structure, and physical plant age. The formula for the FSI uses four financial ratios from an organization's balance sheet and income statement.

Table 5: Financial Strength Index Dimensions and Measures

Dimensions of Financial Strength	Measured by
Profits	Total margin
Liquidity	Days cash on hand
Debt expense	Debt financing %
Age of physical facilities	Average age of plant

Each of the four measures is “normalized” around a predefined average for the measure. Adding the four measures creates a composite indicator of total financial strength. Thus, the formula for calculating the FSI is as follows:

$$\text{FSI} = [(\text{Total Margin} - 4.0) / 4.0] + [(\text{Days Cash on Hand} - 50) / 50] \\ + [(50 - \text{Debt Financing Percent}) / 50] + [(9.0 - \text{Average Age of Plant}) / 9.0]$$

Organizations that have high margins, lots of cash, little debt, and new facilities are in better financial condition and have higher FSI. On the other hand, entities with losses, little cash, lots of debt, and old physical facilities have lower ratios. Table 6 is a suggested guide to rate FSI.

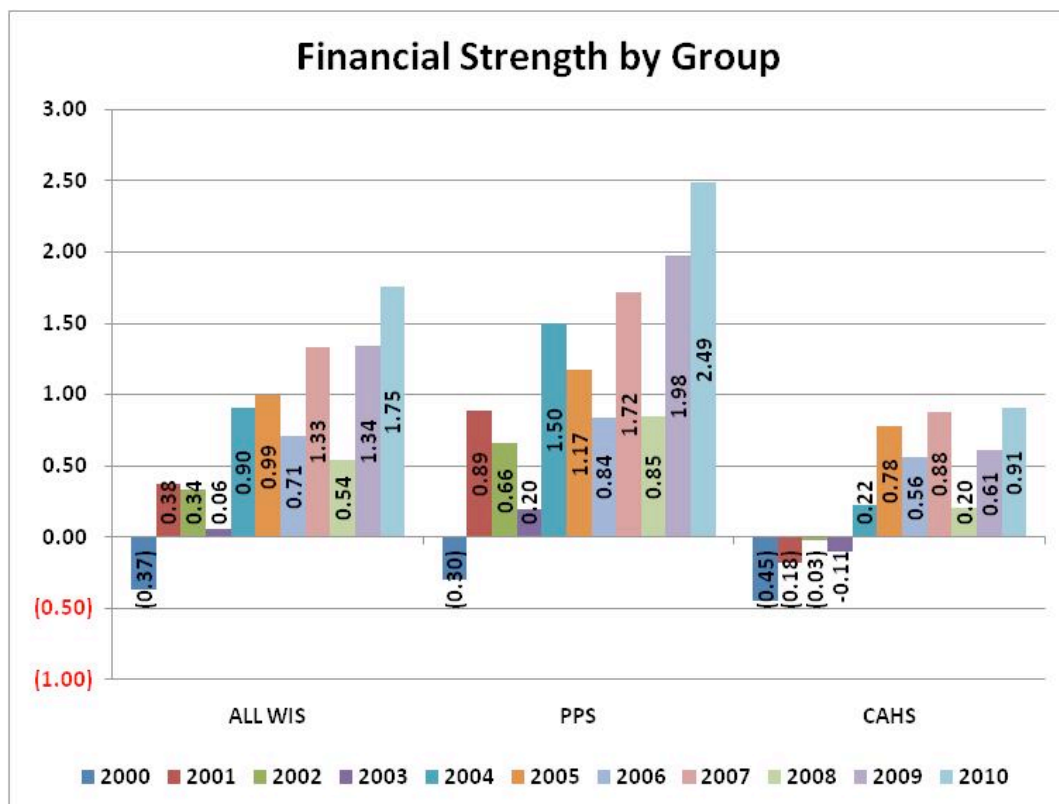
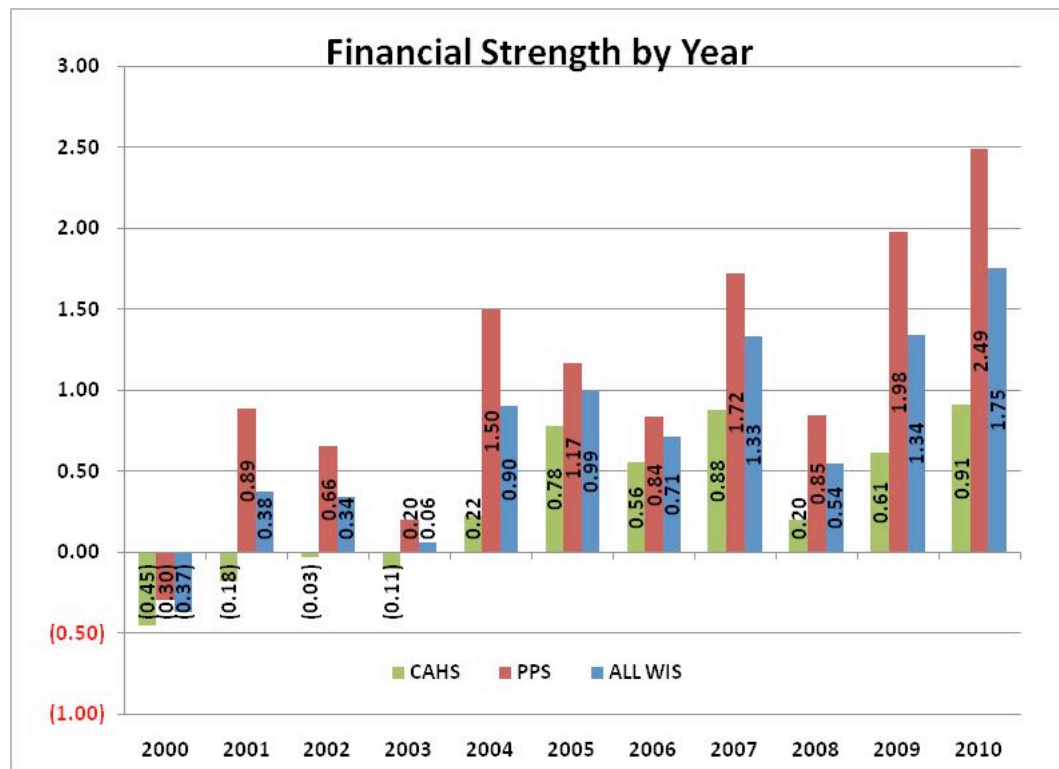
Table 6: Financial Strength Index Rating Guide

Score	Financial Health
Greater than 3	Excellent
0 to 3	Good
-2 to 0	Fair
Less than -2	Poor

FSI seeks to combine the effects of four financial performance ratios in order to reveal the impact of changes in the organization. If one area of the organization’s finances improves but others regress, the FSI will properly reflect the tradeoff. For example, if an entity increased its cash position simply by issuing additional debt, the improvement in cash on hand will be offset by the increase in debt financing percent. No single financial measure, however, is capable of assessing the financial health of an organization.¹

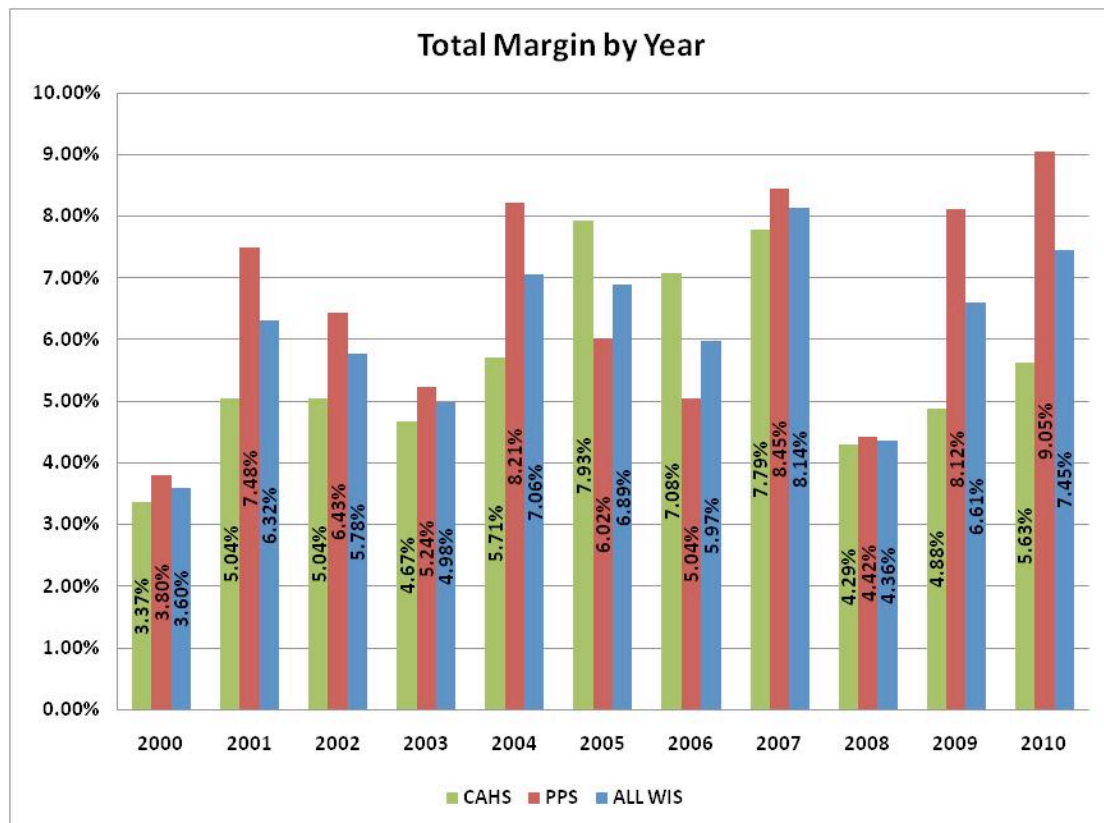
Prior studies showed an improvement in the FSI for CAHs and PPS facilities in 2004, decreasing in 2005 and 2006 and increasing again in 2007. The FSI for both groups decreased in 2008. The following graph shows improvement in the FSI in 2009 and 2010. The FSI for PPS in both 2009 and 2010 continue to be higher than for CAHs. The 2010 FSI for both groups is “Good” according the FSI rating guide (See Table 6).

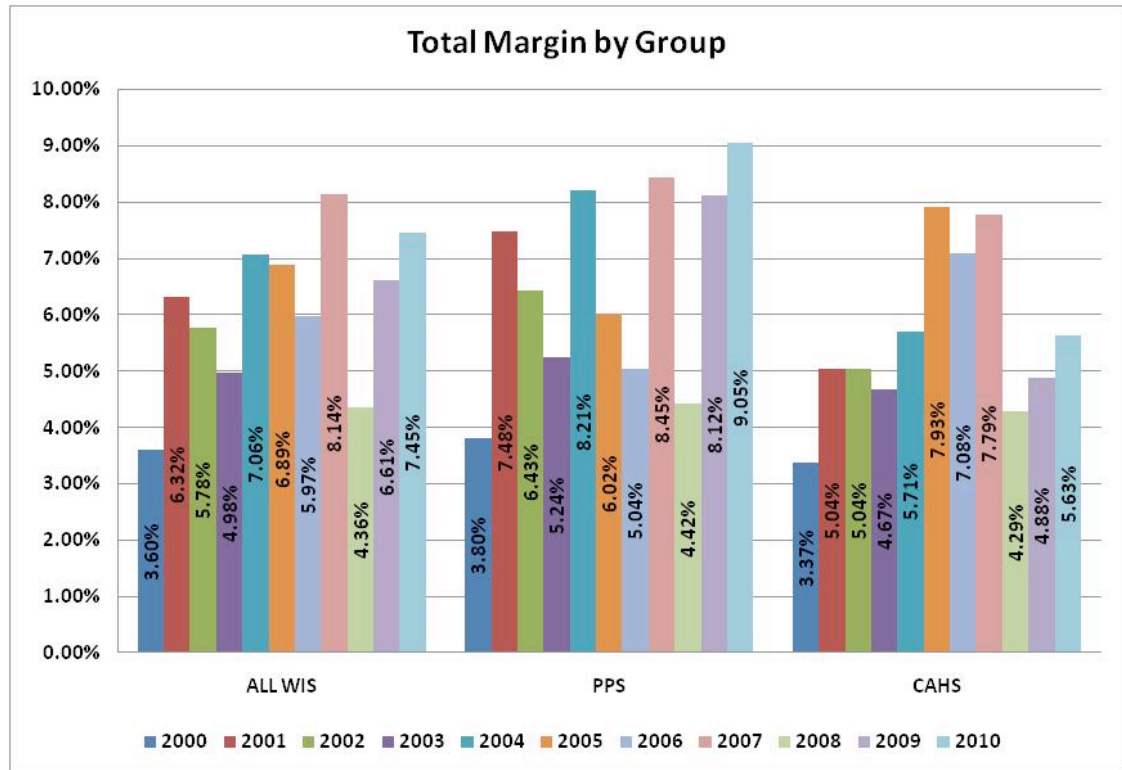
¹ SOURCE: “The Financial Strength Index: A Measure of a Firm’s Overall Financial Health,” by William O. Cleverley, Ph.D., President, Cleverley & Associates, and Andrew E. Cameron, Ph.D., MBA, Assistant Professor, Ohio State University. Published in the January 2003 issue of HFMA’s newsletter, *Executive Insights*.



TOTAL MARGIN

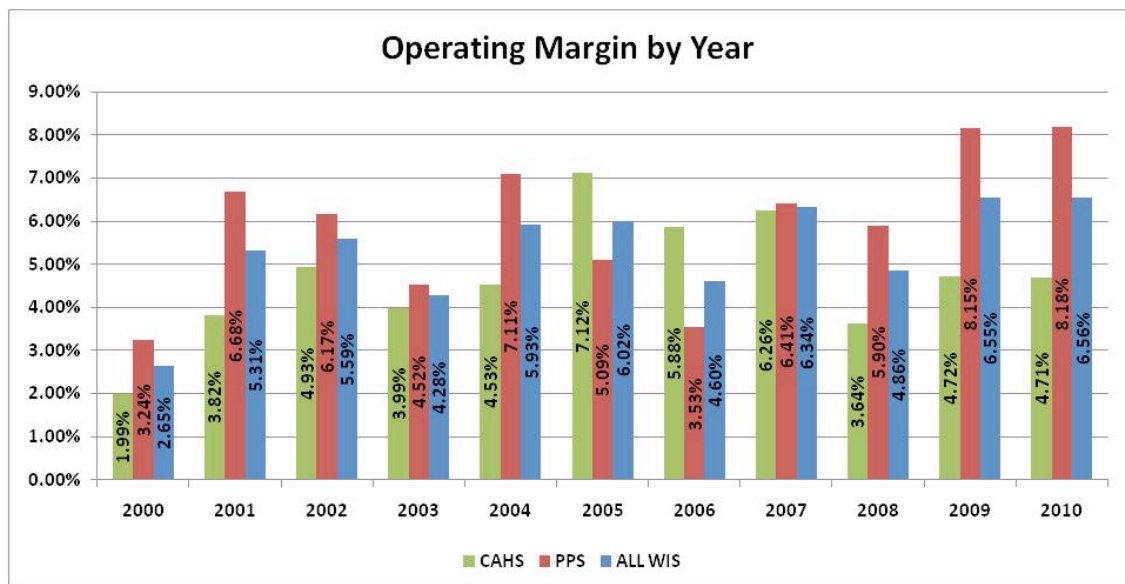
As indicated in Table 4, Total Margin represents the percent of Net Income to Net Patient Revenue. Total Margin ratio includes both operating and non-operating income. Increasing trends are favorable financial indicators. From 2000 through 2004, CAH's Total Margin lagged behind PPS facilities. In 2005 and 2006, Total Margin for CAHs was higher than for PPS hospitals. In 2007 and 2008, CAHs fell slightly below PPS but still had a Total Margin of approximately 8%. In 2009, Total Margin for CAHs increased slightly over 2008 to 4.88% while PPS facilities experienced a more dramatic increase to just over 8%. In 2010, CAH's Total Margin continued to improve to 5.63% and PPS facilities also showed a small increase to 9.05%.

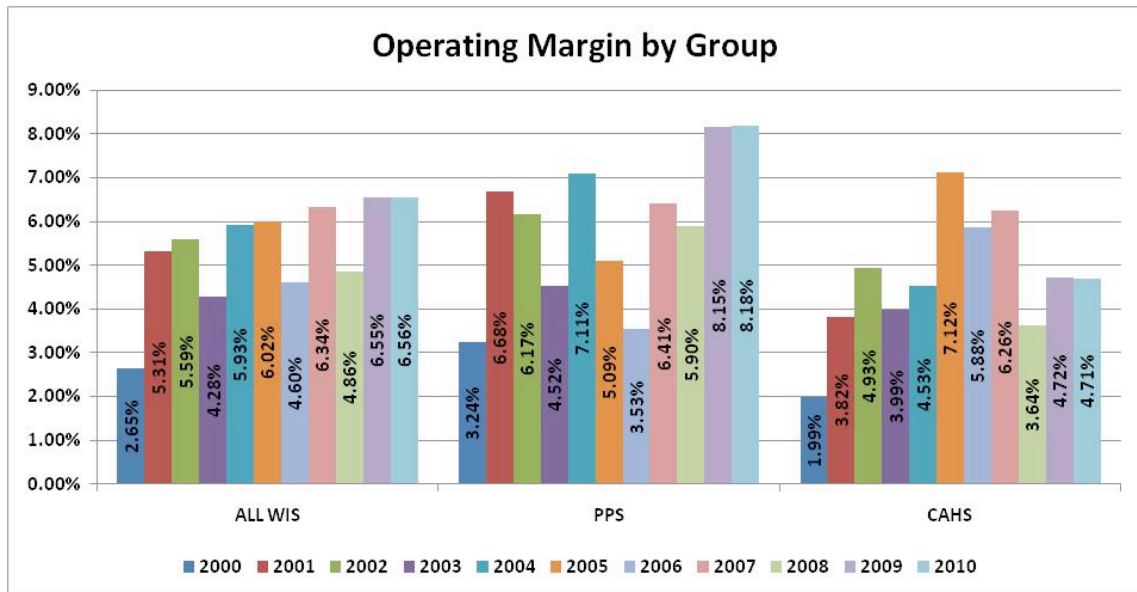




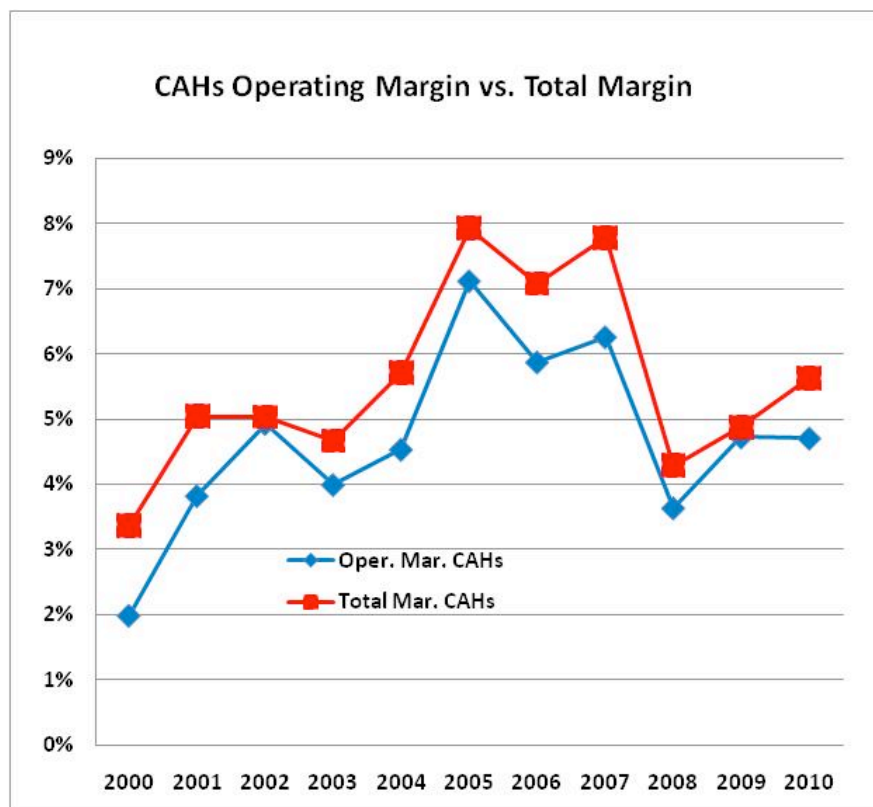
OPERATING MARGIN RATIO

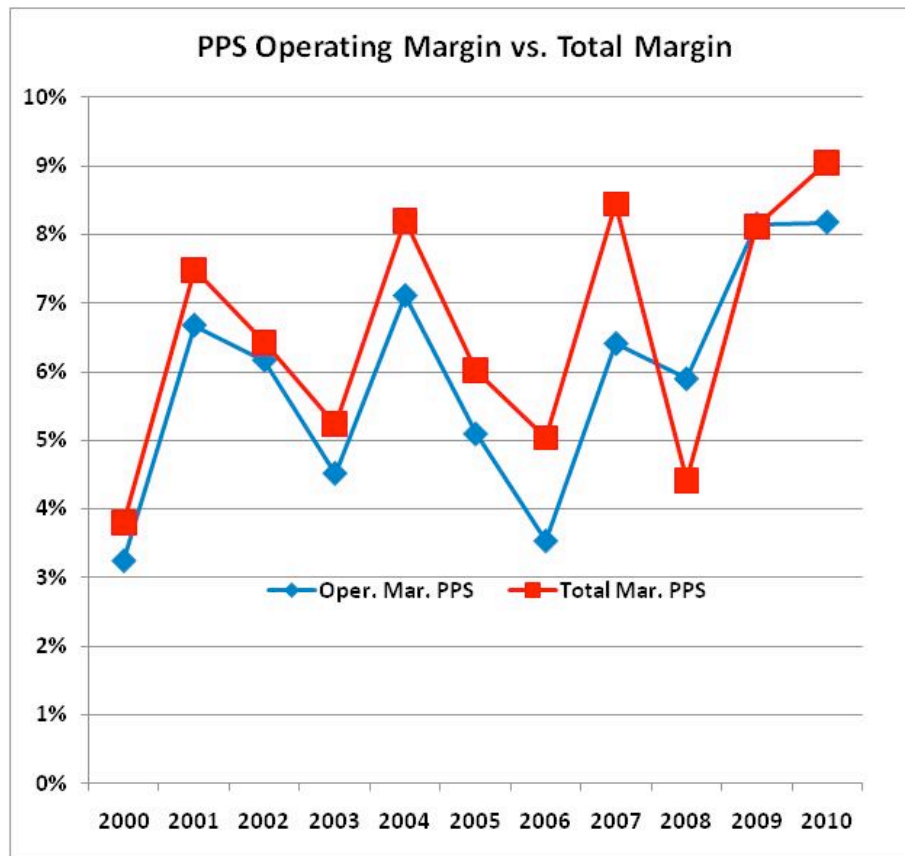
The Operating Margin ratio measures the percent of operating income to total operating revenue. It is used by many analysts as a primary measure of operating profitability. The Operating Margin ratio does not reflect investment income or losses. The following graphs indicate that CAHs continue to have lower Operating Margins than PPS facilities. Operating Margins increased in 2009 over 2008. Operating Margins in 2010 were basically unchanged from 2009 for both groups.





As discussed in the 2009 study, Total Margins for all groups in 2008 were approximately the same (4%). Because of the investment performance in 2008, PPS facilities experienced higher investment (non-operating) losses than CAHs. These non-operating losses resulted in PPS Total Margins about the same as for CAHs. The Operating and Total Margin for both groups were higher in 2009 than 2008 (see graphs below). PPS Operating and Total Margins were significantly higher than for CAHs in 2009 and 2010.



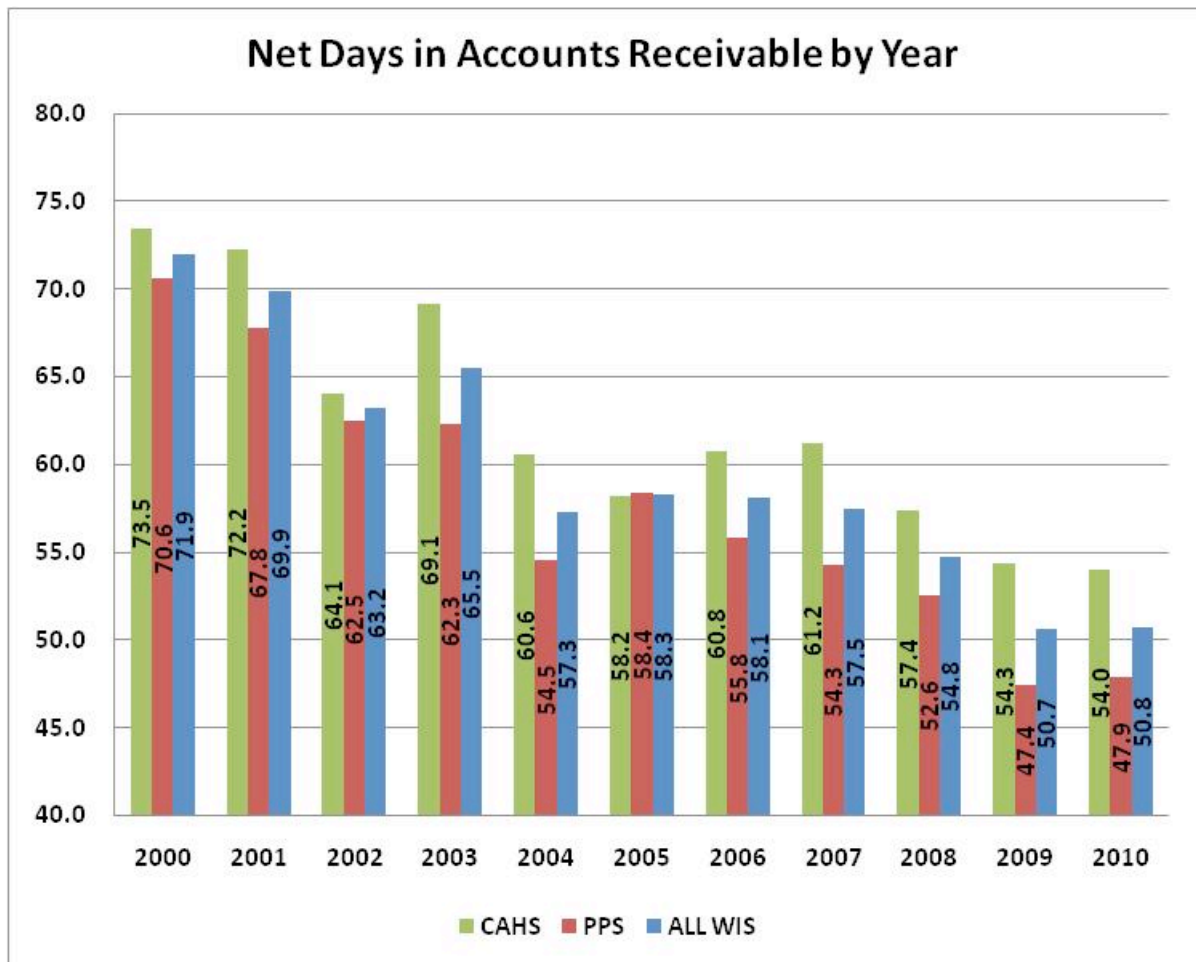


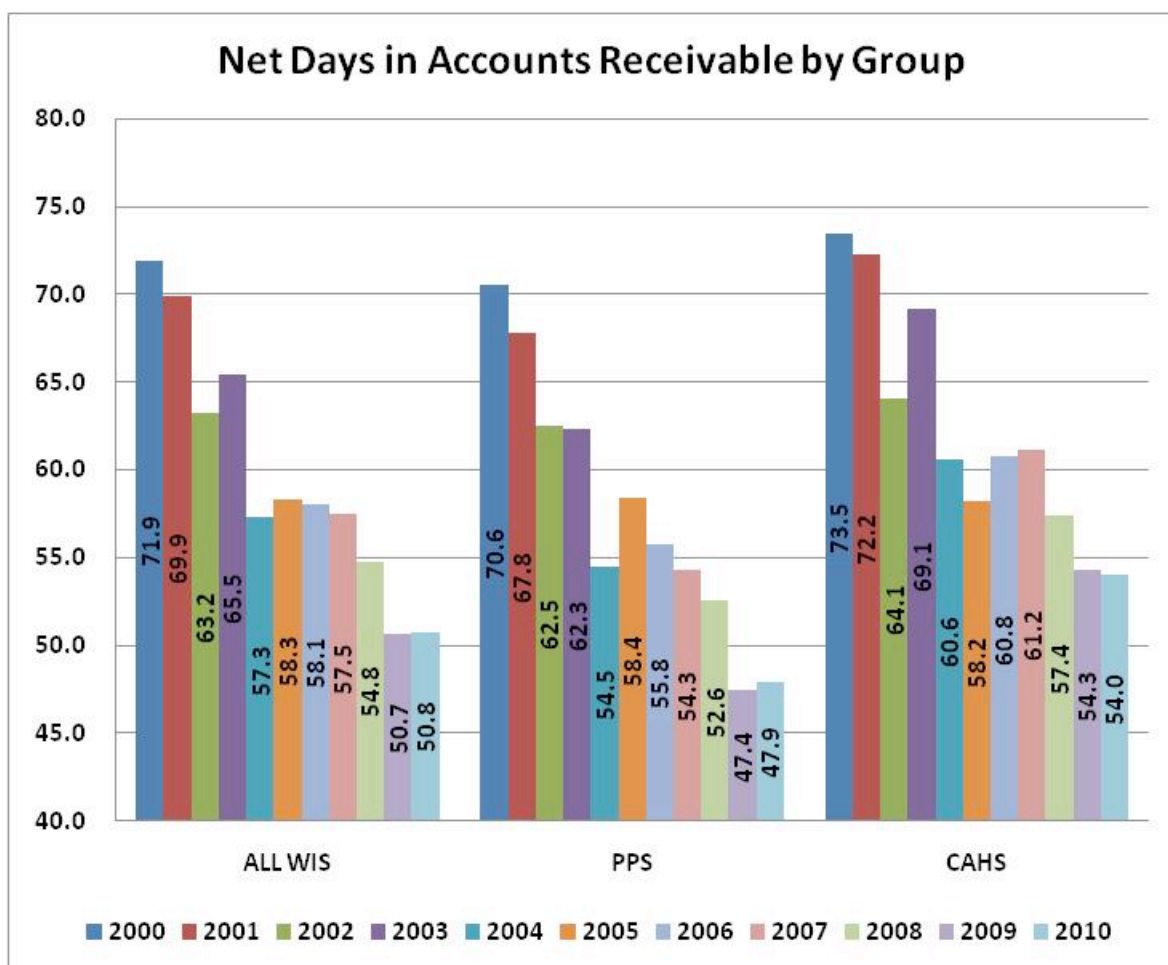
NET DAYS IN ACCOUNTS RECEIVABLE

Net Days in Accounts Receivable is a ratio that indicates how quickly services are billed and paid. Generally, low numbers for this ratio are favorable. Decreasing trends show improvement in the collection process. Lower Net Days in Accounts Receivable is a positive trend that usually translates into higher cash account balances. Both groups have shown a general improvement in collecting accounts receivable from 2000 through 2009. CAH's Net Days increased in 2006 and 2007 but decreased in 2008. Net Days for both groups remained about the same from 2009 to 2010. This may indicate improvements in collection efforts are having diminishing effects. CAH's Net Days in Accounts Receivable for 2010 was about six days higher than for PPS facilities. Possible reasons for this variance may include technology, payer mix, collection agency effectiveness, or more self-pay patients.

Billing for medical services provided to patients has been a very complicated process for many years. However, in the near future, a major change is going to take place in the way hospital's code for provided services. Hospitals currently use the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) coding system, which was developed in the 1970's. ICD-9-CM no longer fits with the 21st century healthcare system. ICD-9-CM is used for many more purposes today than when it was originally developed and is no longer able to support current health information needs.

The need to replace ICD-9-CM was identified in 1993, when the National Committee on Vital and Health Statistics (NCVHS) reported that ICD-9-CM was rapidly becoming outdated. Similarly, the Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services (CMS), recommended that steps should be taken to improve the flexibility of ICD-9-CM or replace it with a more flexible option sometime after the year 2000. Many industrial nations have already upgraded to a new coding system, the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS). So the US Department of Health and Human Services (HHS) mandated the replacement of the ICD-9-CM code sets used by medical coders and billers to report health care diagnoses and procedures with ICD-10 code sets, effective Oct. 1, 2013. ICD-10-CM/PCS will enhance accurate payment for services rendered and facilitate evaluation of medical processes and outcomes. Upgrading to ICD-10-CM/PCS will better achieve the benefits of an electronic health record. In spite of several potential long-term benefits, the transition to the ICD-10-CM/PCS will be a challenge for all hospitals. The potential for an increase in Days Revenue in Accounts Receivable and corresponding decrease in Days Cash on Hand exists. Hospitals will need to aggressively implement ICD-10-CM/PCS.

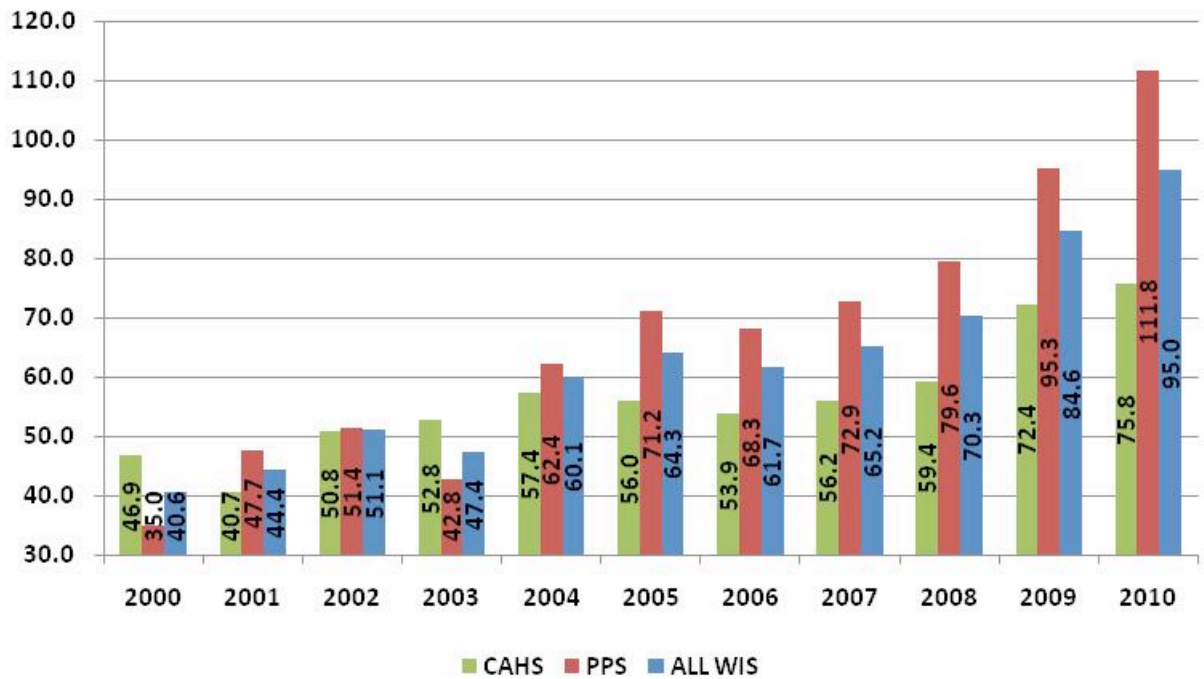




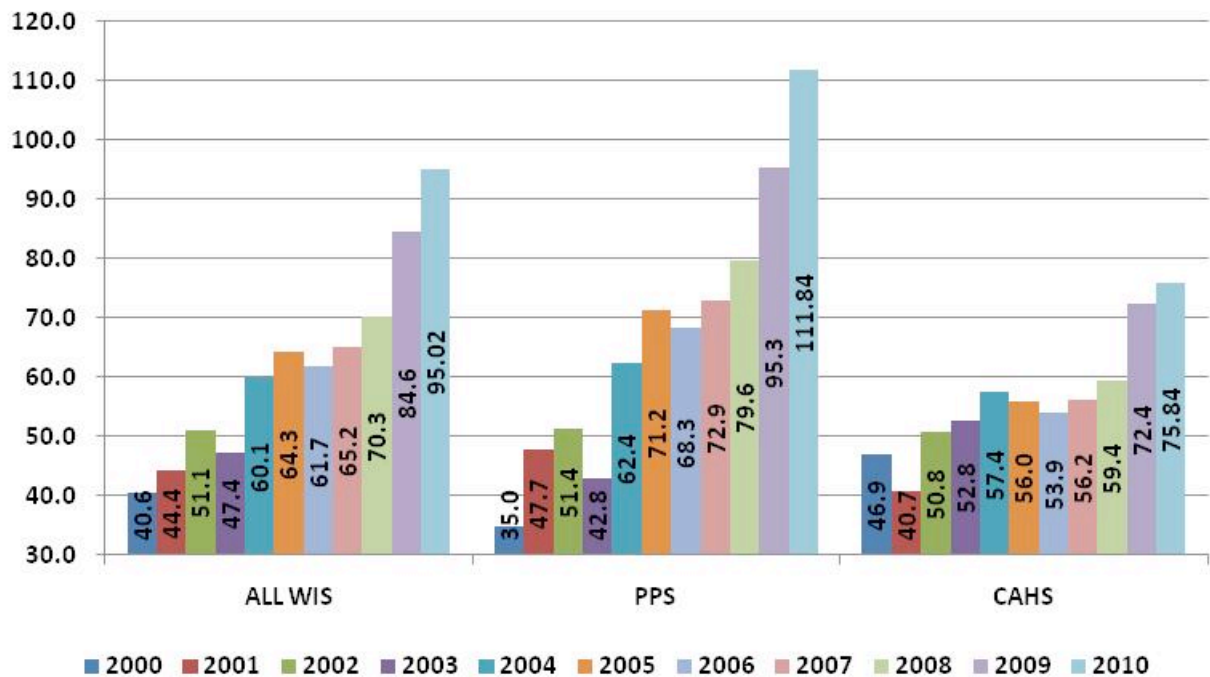
DAYS CASH ON HAND

The Days Cash on Hand ratio indicates how many days' cash the facility has based on the average daily cash expenditures. High ratios are favorable and an increasing trend in this ratio is also favorable. The following graphs show a substantial increase for both groups in 2009. As mentioned previously, Days in Accounts Receivable decreased in 2009. Increasing Days in Accounts Receivable has a negative impact on Days Cash on Hand. The previous discussion regarding the major imminent change to ICD-10 potentially could decrease Days Cash on Hand. Days Cash on Hand showed a higher increase in 2010 for PPS facilities than for CAHs.

Days Cash On Hand by Year



Days Cash On Hand by Group



DEDUCTION RATIO

The deduction ratio shows the percent difference between hospital charges and actual cash paid for services provided. The deductions include government payers such as traditional Medicare and Medicaid, Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Medicare Advantage plans, Medicaid HMO plans, and private pay discounts including charity care. During the study period, bad debts are considered expenses and are not included in the deduction ratio. However, in July 2011, the Financial Accounting Standards Board (FASB) published an Accounting Standards update for Healthcare Entities entitled “Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities”. The amendments in this update require certain health care entities to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). This change to the treatment of bad debts will affect future financial statements and related financial ratios. Although all periods covered in this report treat bad debts as an expense, future financial analysis will need to address this change.

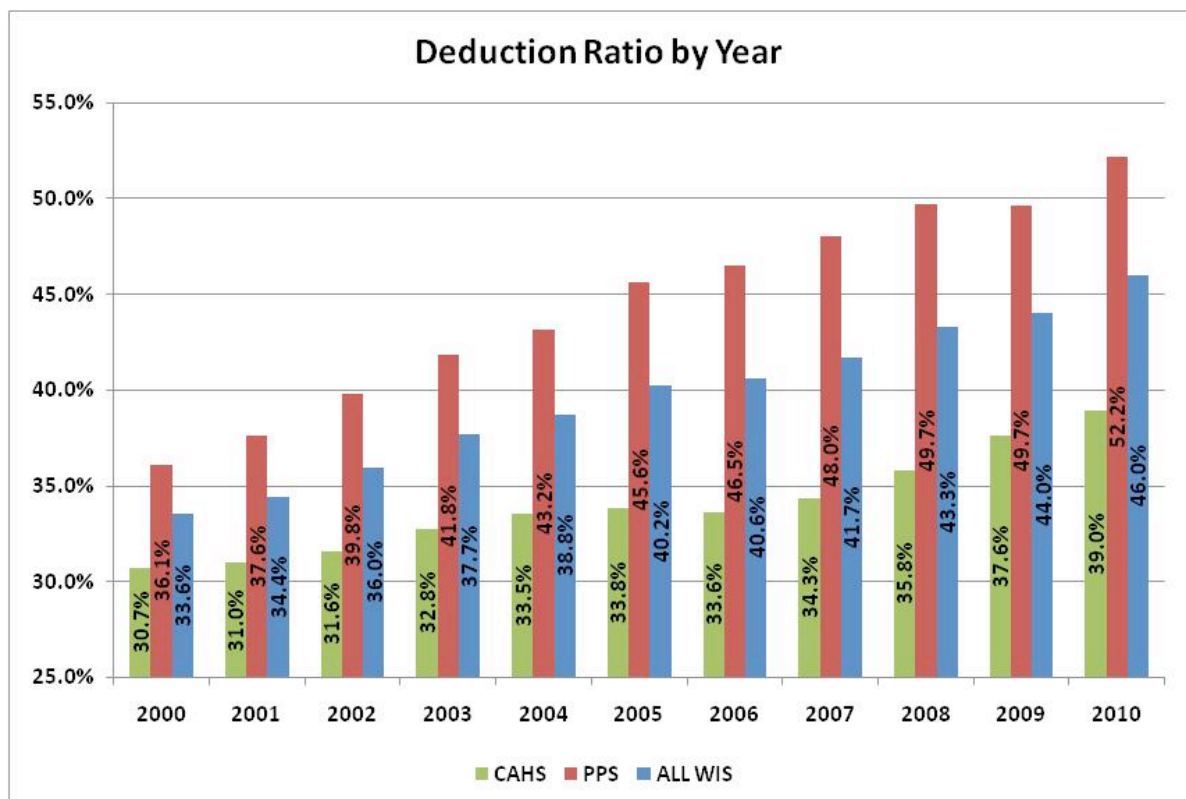
It is commonly understood that increases in Medicare payments, the largest payer for most facilities, has failed to keep up with costs and related charges. Table 7 shows the history of average charge increases compared to Medicare inpatient charges. The average charge increase column is taken from the Wisconsin Health Information Center Hospital Rate Increase reports. Wisconsin state law requires hospitals to report certain price increases to the Information Center. This column shows the average of those facilities reporting price increases. The increase in Medicare payments is taken from the Federal Register rules for the respective years. The Federal Registers include a Table summarizing the percentage change in total payments per case to the prior year. The gap in increases in prices over changes in Medicare inpatient prospective payments contributes to the rise in the deductible ratio. For CAHs, average charge increases have also increased more than cost-based reimbursement for traditional Medicare and potentially Medicare Advantage plans.

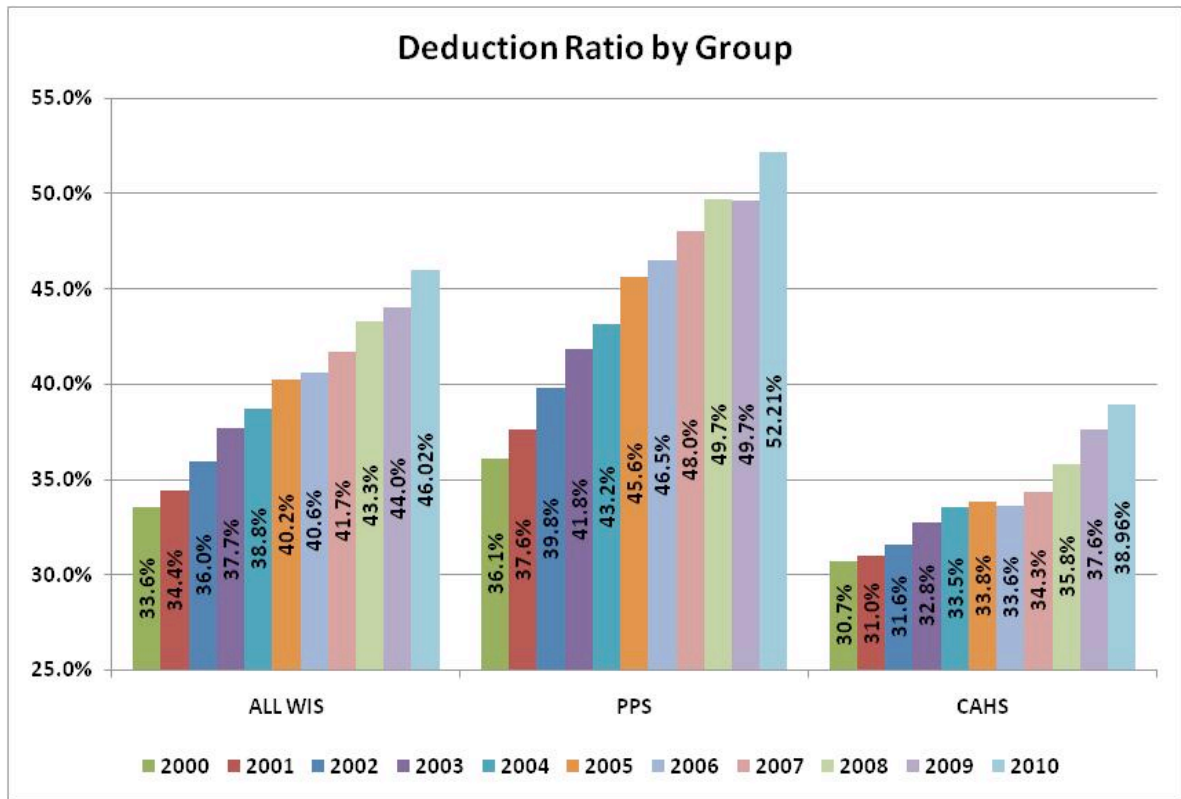
Wisconsin Medicaid fee-for-service reimbursement originally was intended to be based on Medicaid determined costs, similar to the Medicare cost principles. However, major changes to the Wisconsin Medicaid State plan have been implemented recently.

Table 7: Wisconsin Average Price Increases vs. % Change in IPPS Payments Per Case

	WI	CMS IPPS
	Average	% Chg in
	Price	Payments
<u>Year</u>	<u>Increase</u>	<u>Per Case</u>
2000	7.14%	-0.90%
2001	7.11%	0.30%
2002	7.35%	2.10%
2003	6.77%	0.40%
2004	6.47%	1.80%
2005	5.98%	5.10%
2006	5.94%	3.50%
2007	6.23%	3.50%
2008	5.99%	0.60%
2009	5.74%	0.70%
2010	5.28%	1.90%

The following graph indicates a steady increase in the deduction ratio for all groups from 2000 through 2010. It also shows a much higher ratio for PPS than for CAHs. Payer mix, managed care penetration, and charge structure are three reasons the deduction ratio may be higher for some facilities.



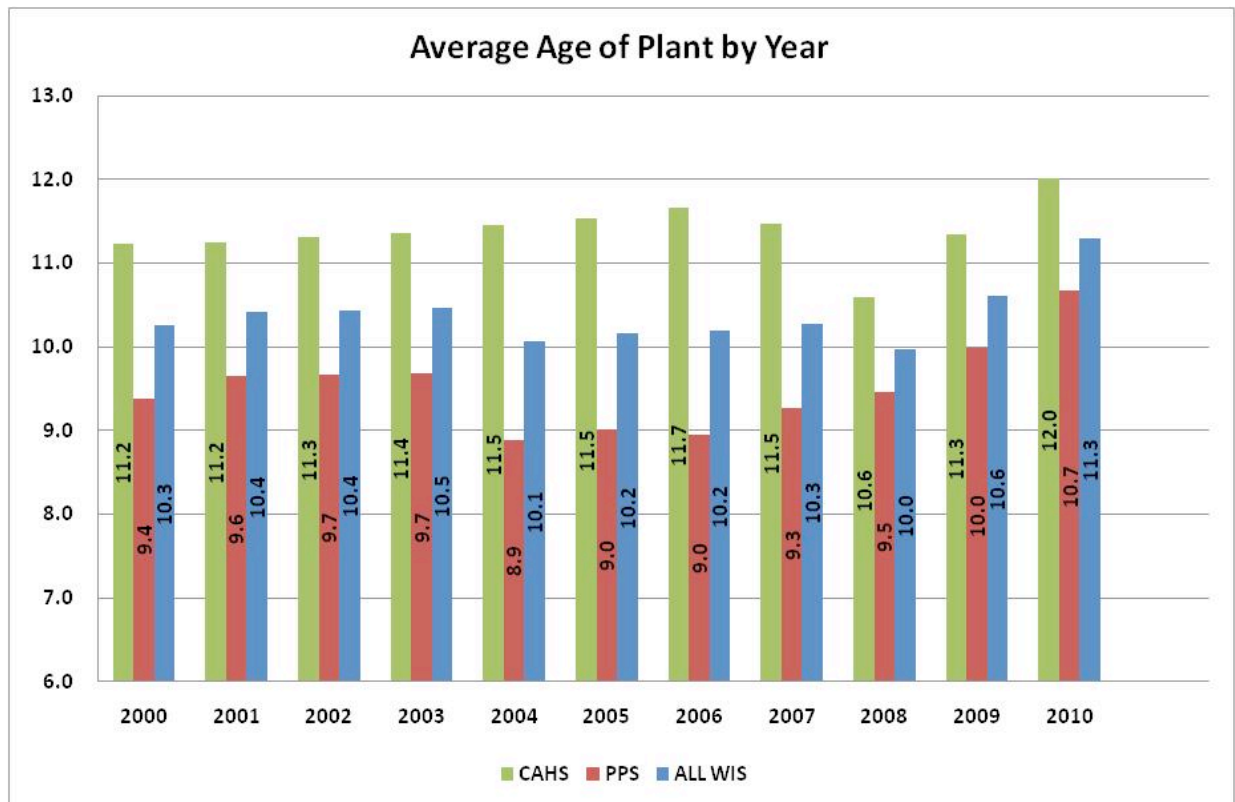


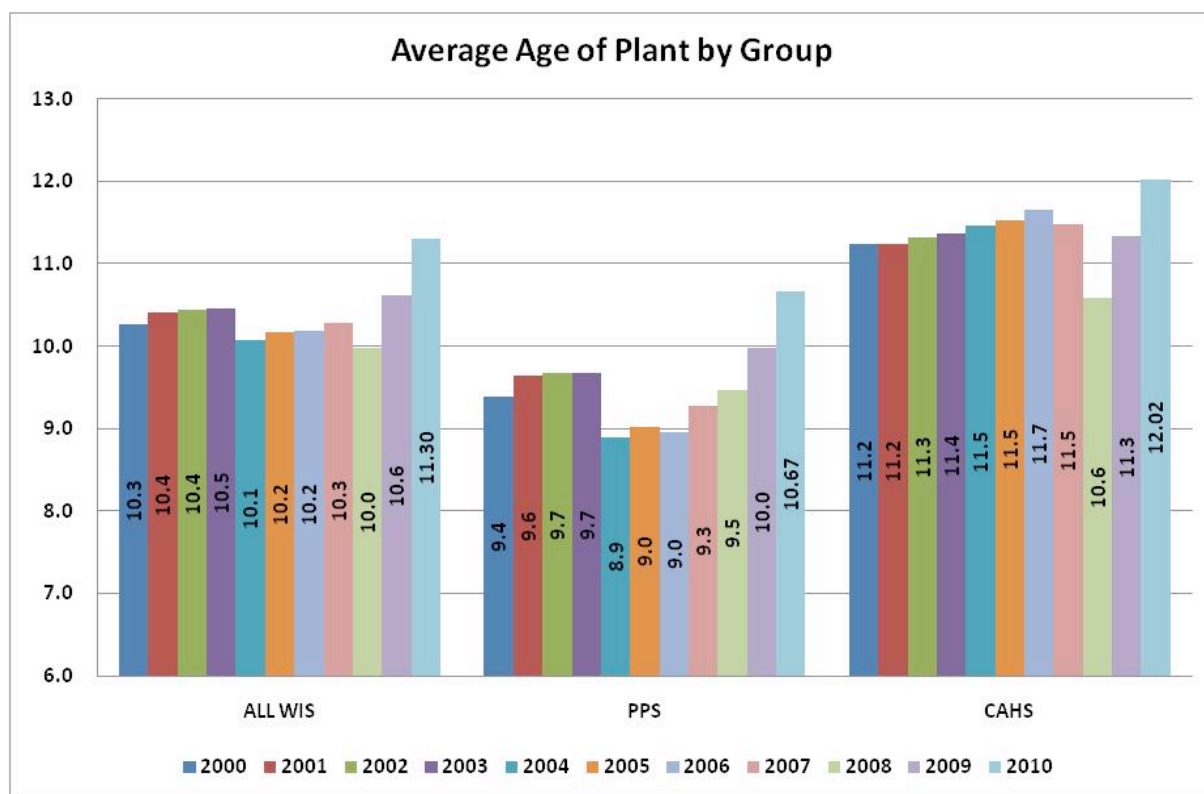
AVERAGE AGE OF PLANT

Many hospitals, both PPS and CAHs, struggle to replace outdated facilities and equipment. Average Age of Plant is typically used as a benchmark to measure capital improvements. It is generally felt that the Average Age of Plant should be less than 10.0, and some financial analysts feel that it should be closer to 7.5. Average Age of Plant is calculated by dividing Accumulated Depreciation by Depreciation Expense. Lower ratios and decreasing trends are usually associated with financially strong organizations. The following graphs show a decrease in Average Age of Plant for the All Wisconsin hospitals in 2008 to 10.0. However, the graph also indicates that the Average Age of Plant increased for all hospitals in 2010 to 11.3. Average Age of Plant for both groups is the highest since the year 2000. CAH Average Age of Plant continues to be higher than for PPS facilities. Although many factors determine how much money hospitals invest in capital, the graph would seem to indicate that CAH status is not helping rural hospitals modernize plants and equipment. Also, Average Age of Plant for both groups increased in the last two years.

One factor which may affect future capital investment and the resulting Average Age of Plant ratio is the American Recovery and Reinvestment Act of 2009 (ARRA). This legislation is intended to help provide hospitals the funding and incentives to implement systems such as Nurse Documentation, Electronic Medication Administration Records, Bedside Medication Verification Systems, or Computerized Practitioner Order entry. Utilized correctly, these systems can improve efficiency and the quality of patient care. This program is further discussed in the Health Information Technology section of this study.

Access to capital continues to be one of the most pressing needs of all hospitals. Smaller hospitals usually find it more difficult to access capital than larger organizations. Many rural hospitals are due for major renovation or replacement. Aged facilities can become very inefficient and affect quality of care and patient safety. Since 2008, many hospitals have experienced more difficulty accessing capital. Even financially strong hospitals have more limited borrowing options, higher cost of capital, and more restrictive debt terms. Capital needs continue to be near the top of the list of priorities for rural hospitals. Hospitals that cannot obtain capital may even need to secure partners or merge with larger organizations to access needed capital resources.



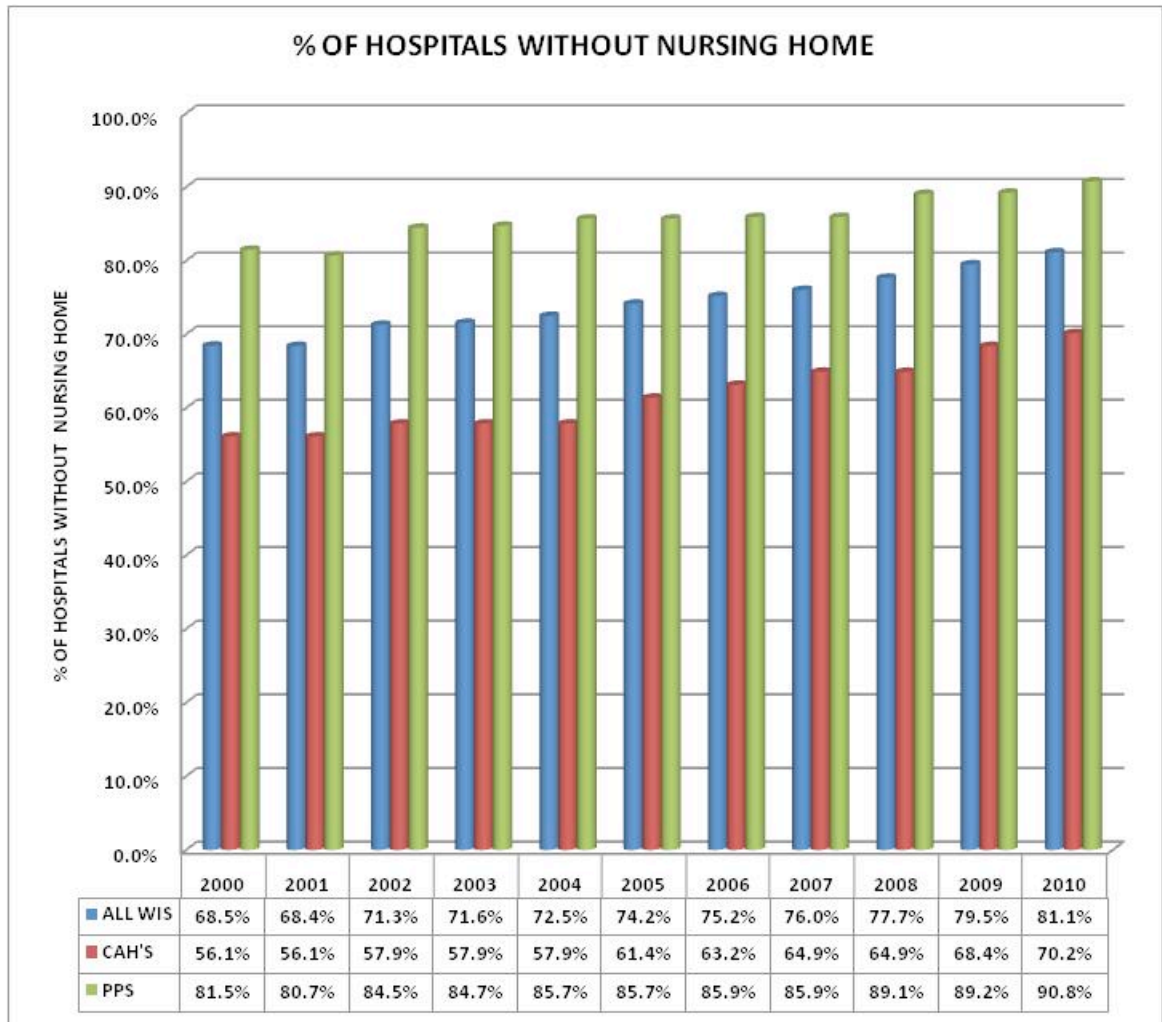


CHANGES IN SERVICES

Comparing changes in services hospitals provide from one year to the next is of limited value. However, Wisconsin hospitals began converting to critical access status in 1999. We now have eleven years of data from the Annual Survey of Hospitals. This survey for the last several years has been submitted to the WHA Information Center. This is sufficient time to determine if there are trends in what services Wisconsin hospitals are providing. The Annual Survey of Hospitals requires hospitals to report on a very comprehensive list of services. Typically, hospitals must indicate by a code number if the service is provided or not. The possible codes are from 1 to 5. The first 4 codes indicate how and where the service is provided or if the service is available through a contractual arrangement with another provider. Code 5 indicates the service is not available either by the hospital or through a formal contractual arrangement with another hospital or provider. Unlike the prior studies which analyzed the number of CAHs that provided a particular service, this report will determine the % of CAH or PPS facilities that do not provide the service (code 5).

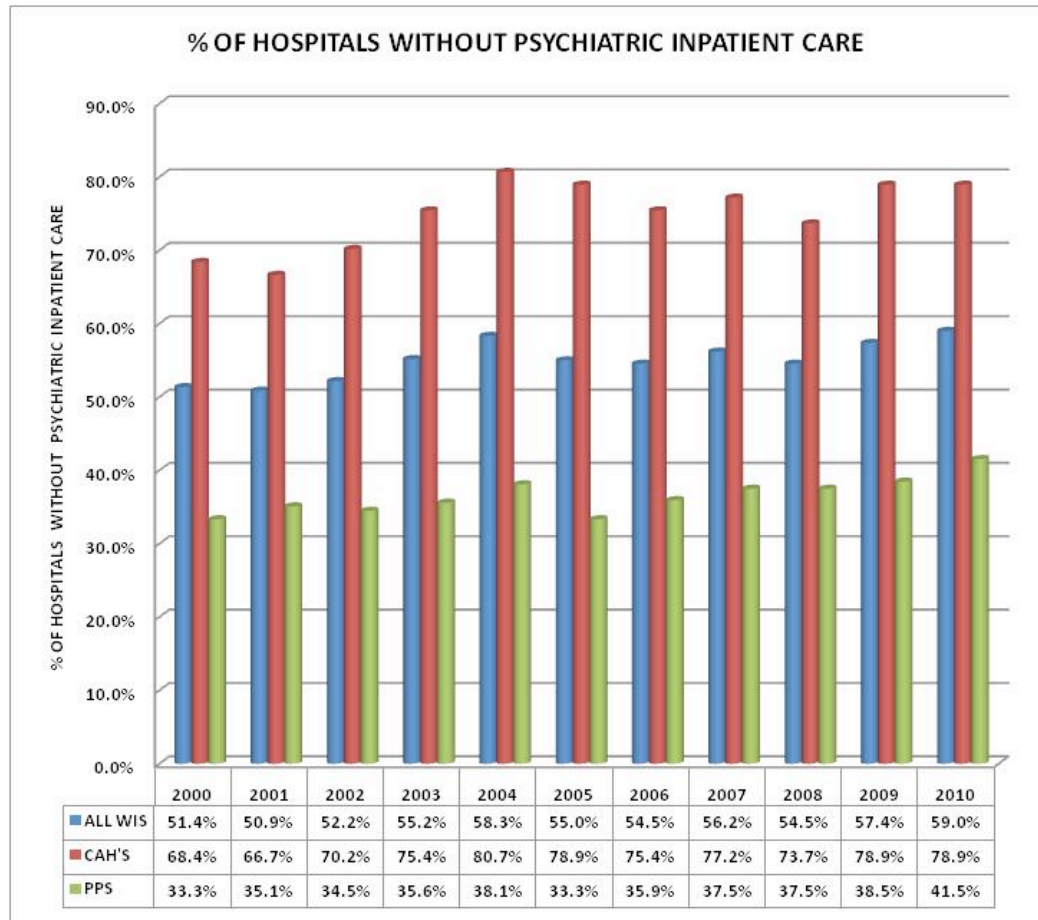
As mentioned, CAHs are reimbursed 101% of the cost they incur for covered hospital inpatient, outpatient, and swing bed services provided to Medicare beneficiaries. Medicare cost-finding reimbursement principles require that all services be subjected to the allocation of overhead costs such as depreciation, utilities, and housekeeping. For example, if a hospital provides long-term care, direct and indirect costs are allocated to Skilled Nursing Facility. Medicare does not pay for all services and their share of the services varies. For example, if a facility provides “Meals-On-Wheels” to members of their community, Medicare does not participate in the costs because this service is not covered by Medicare. Additionally, Nursery and Obstetric services are provided by

almost all facilities but because Medicare beneficiaries are almost exclusively over 65, Medicare utilization is minimal. Another example of how financial considerations may affect which services CAHs provide is SNF. Although the SNF may be Medicare-certified, SNF's are not cost reimbursed. The SNF Medicare payment system is based on prospective Resource Utilization Groups (RUGS). CAHs may face low RUG rates and relatively low volume, the same problems they confronted when they were paid under the Medicare prospective payment system for hospital services. The following graphs show the % of hospitals that do not provide services by CAHs, PPS, and both groups combined.

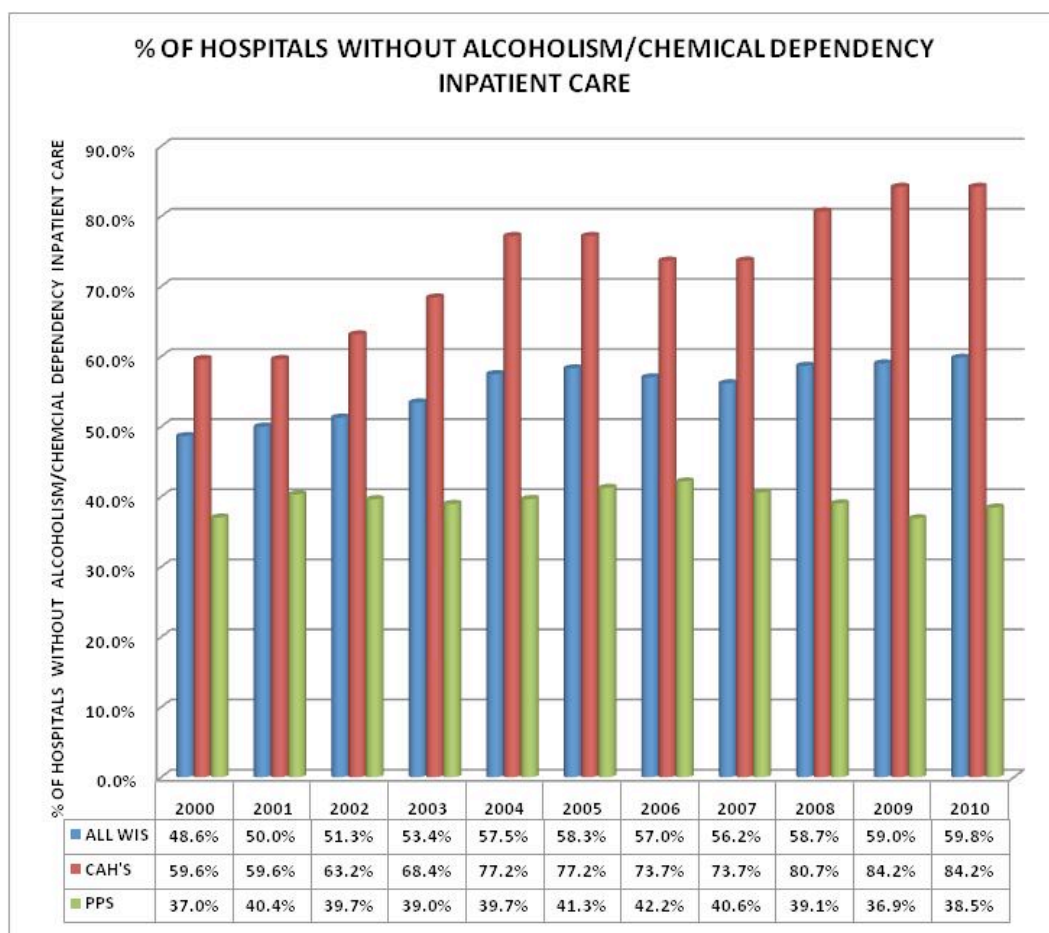


The % of CAHs that do not provide long-term care services has increased from 56% in 2000 to 70% in 2010. The % of CAHs providing long-term care services is still higher than for PPS facilities. In 2010, over 90% of PPS hospitals did not provide this service.

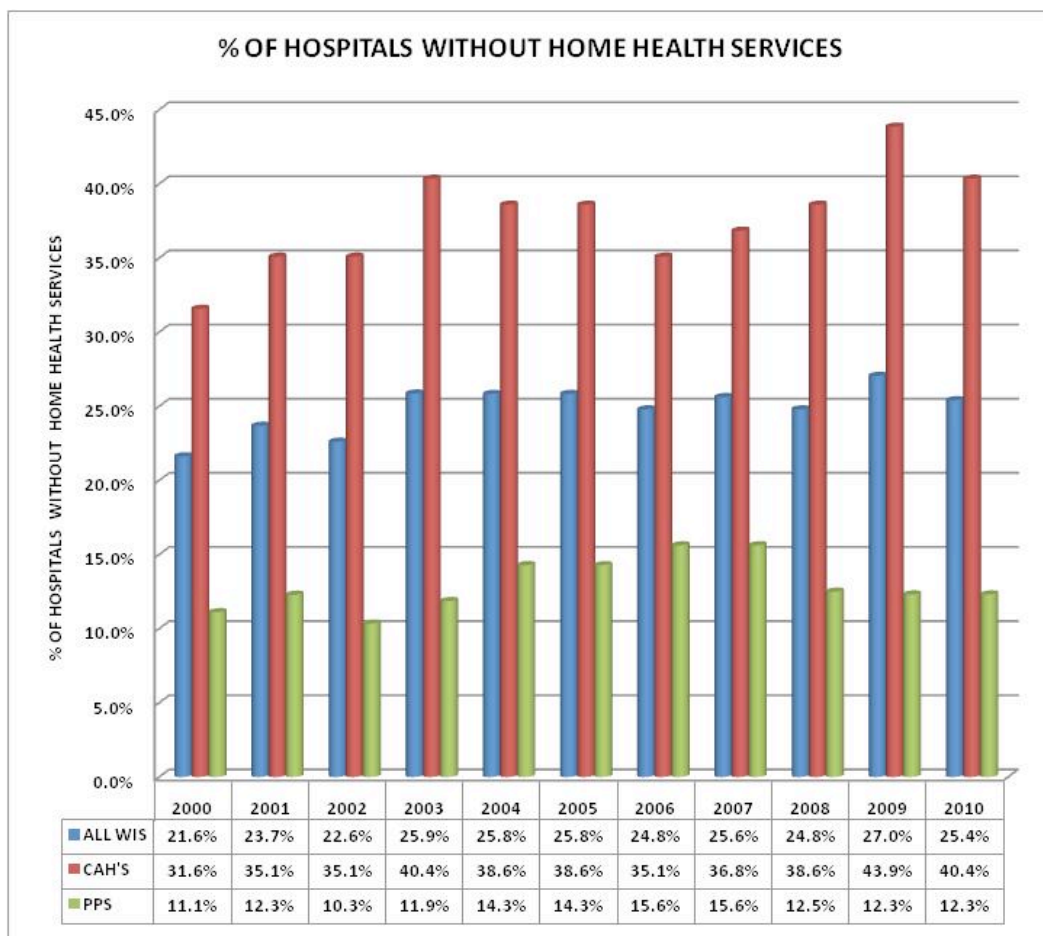
In spite of the fact that the % of PPS facilities that do not provide Psychiatric inpatient care services has increased from slightly over 33% in 2000 to about 41% in 2010, more CAHs do not provide this service than PPS hospitals (almost 79% for CAHs in 2010 versus 41.5% for PPS).



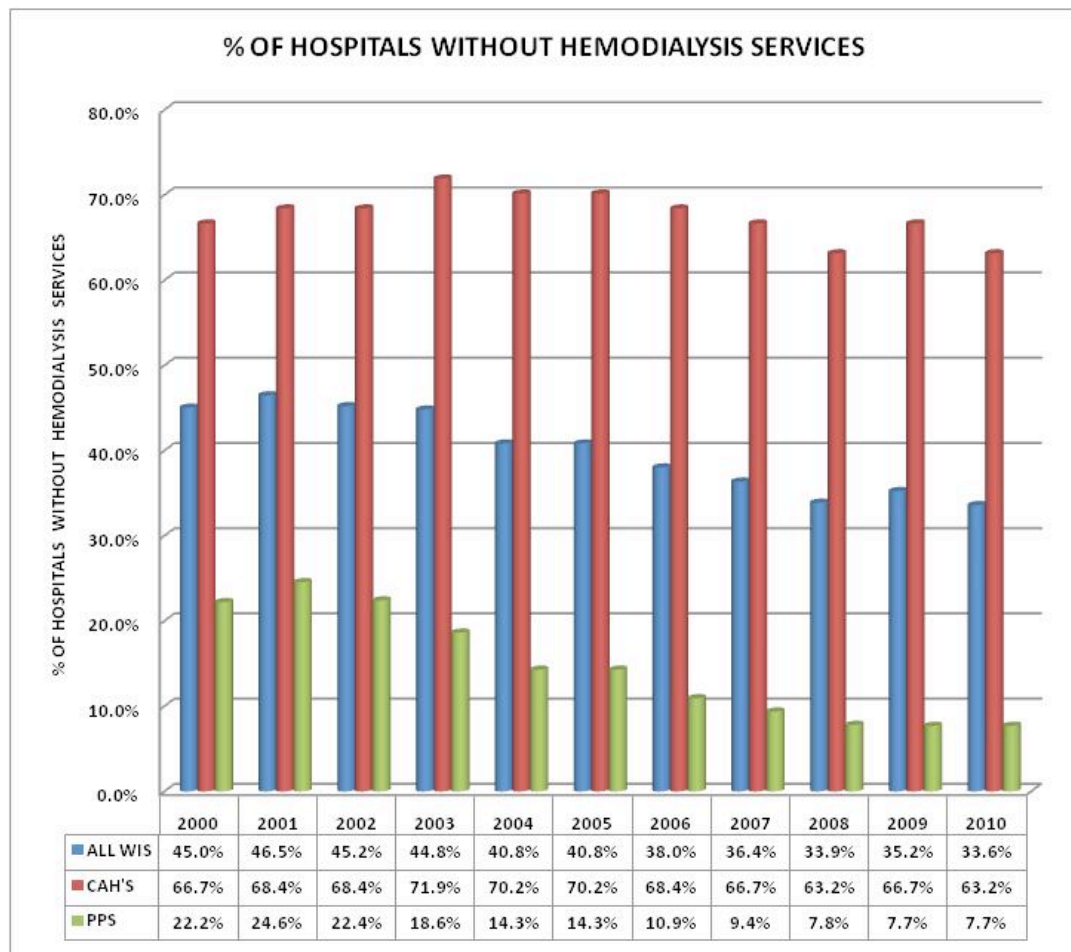
The % of PPS facilities that do not provide Alcoholism and Chemical Dependency Inpatient Care has remained relatively unchanged from 2000 to 2010 (approximately 40%). CAHs, however, have experienced a substantial increase the % of facilities that do not provide this service. The % of CAHs that do not provide Alcoholism and Chemical Dependency Inpatient Care has risen from just under 60% in 2000 to over 84% in 2010.



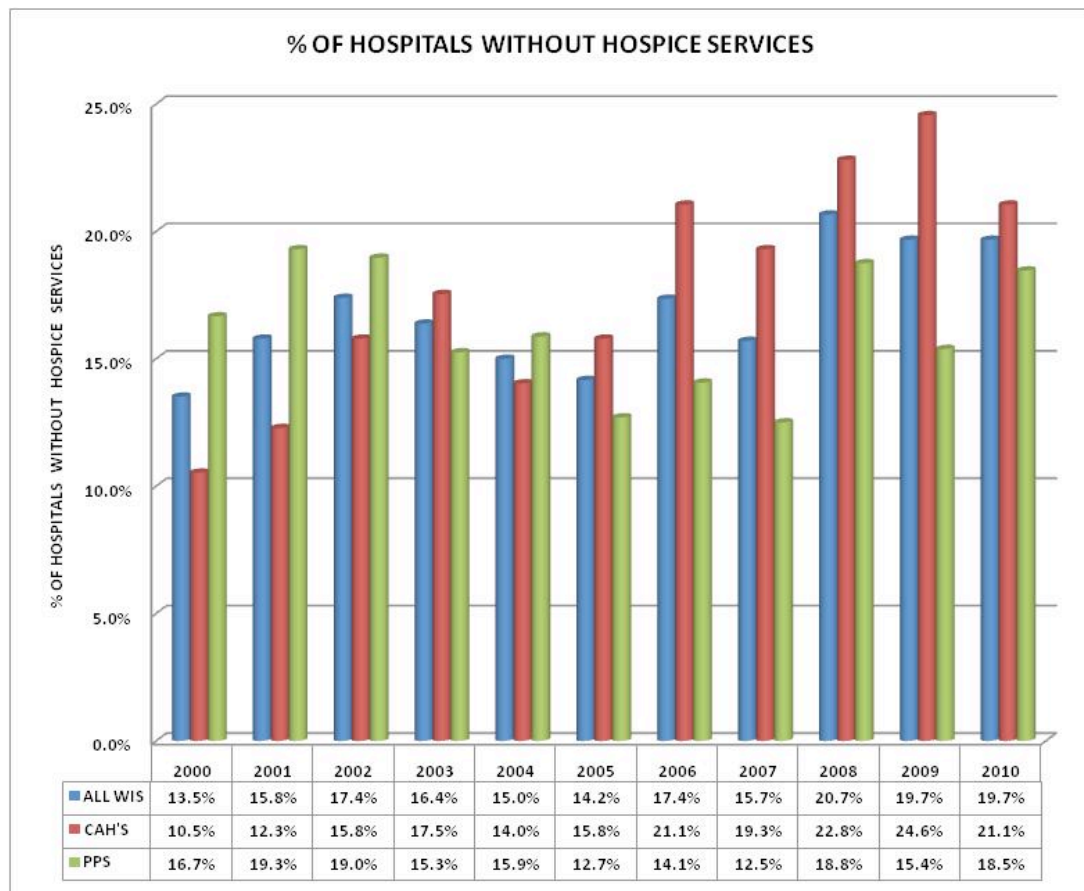
The analysis of Home Health Services shows a similar trend to the prior graph of Alcoholism and Chemical Dependency Inpatient Care service. More CAHs are deciding not to provide Home Health services as the % that do not provide this service has increased from 31% in 2000 to over 40% in 2010. In contrast, the % of PPS facilities that do not provide Home Health Services has remained relatively stable at about 12% from 2000 through 2010.



More PPS hospitals are providing Hemodialysis Services as the % of PPS facilities who do not provide this service has decreased from 22% in 2000 to 7.7% in 2010. In contrast, a much higher % of CAH facilities do not provide Hemodialysis (63.2% in 2010). The % of CAHs that do not provide Hemodialysis has remained about the same since 2000.



The analysis of Hospice Services shows more CAHs are deciding not to provide this service as the % not providing Hospice Care has increased from 10% in 2000 to over 21% in 2010. The % of PPS facilities that do not provide Hospice Services has remained relatively stable, increasing from 16.7% in 2000 to 18.5% in 2010.

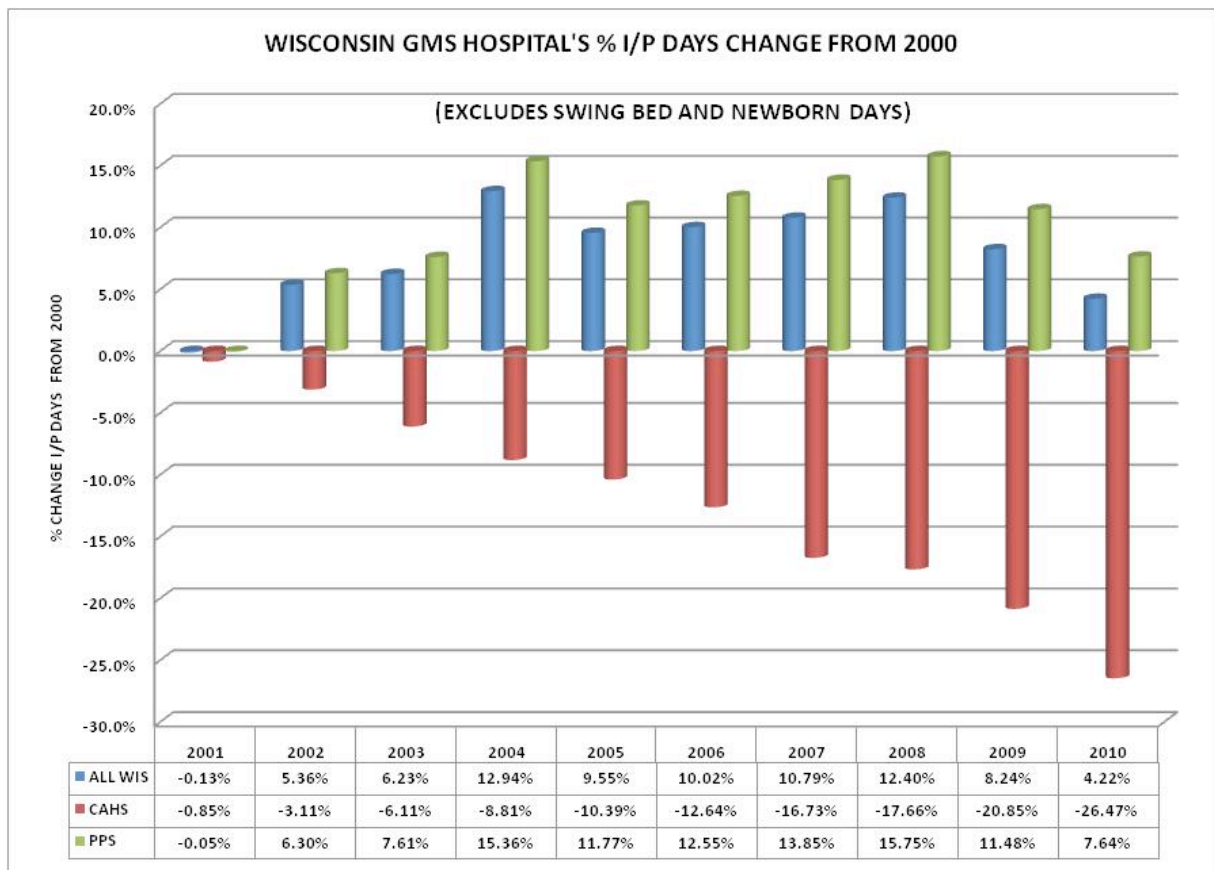


Hospitals decide what services to provide based on a number of factors such as community need, make-up of the medical staff, impact on overall financial performance or to gain advantage over competitors. Each facility must determine which services contribute to the health of their communities as well as their own financial health. Hospitals, either PPS or CAHs, may determine the net financial loss of providing a particular service outweighs any advantages. The financial impact on Medicare cost-based payments of providing certain services can be a factor for CAHs in deciding what services to provide. CAHs may decide that because of the cost report methodology for allocating cost to non-reimbursable service, the service cannot be provided without risking the financial health of the overall organization. PPS facilities may be able to continue to provide some services paid prospectively because their higher volumes help to cover fixed costs. Some services may also have a total positive financial impact on the organization.

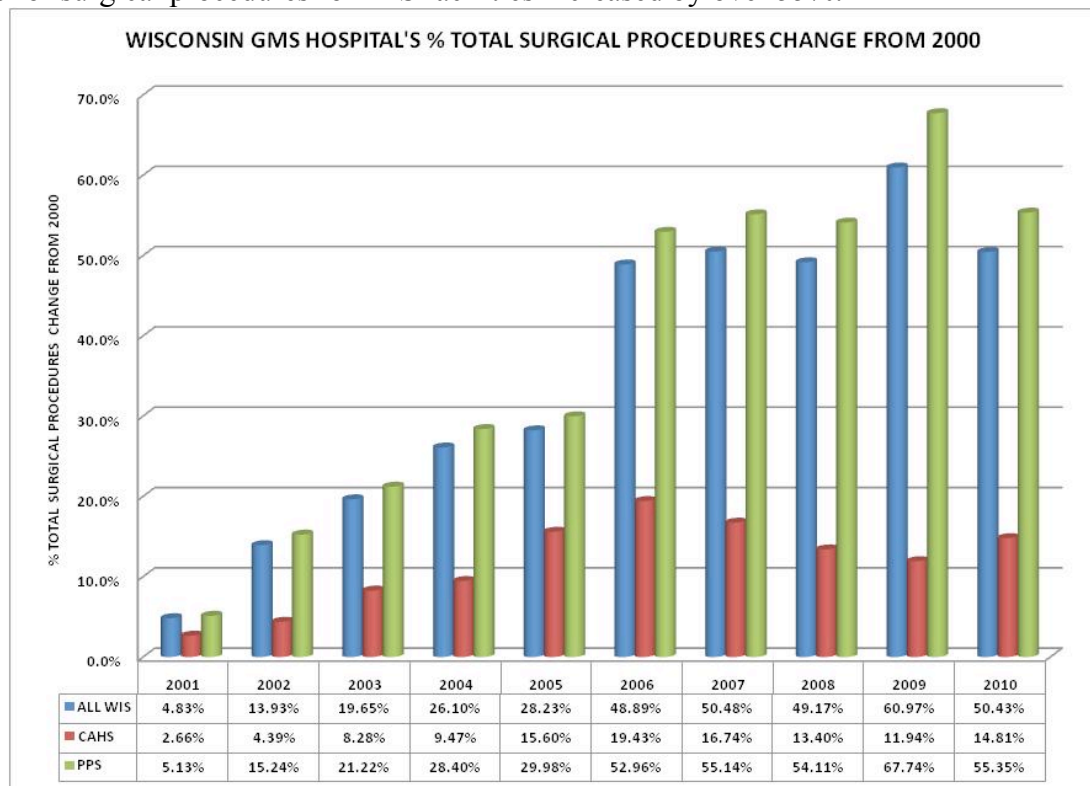
UTILIZATION

The following charts show the percentage change from the year 2000 for several key services.

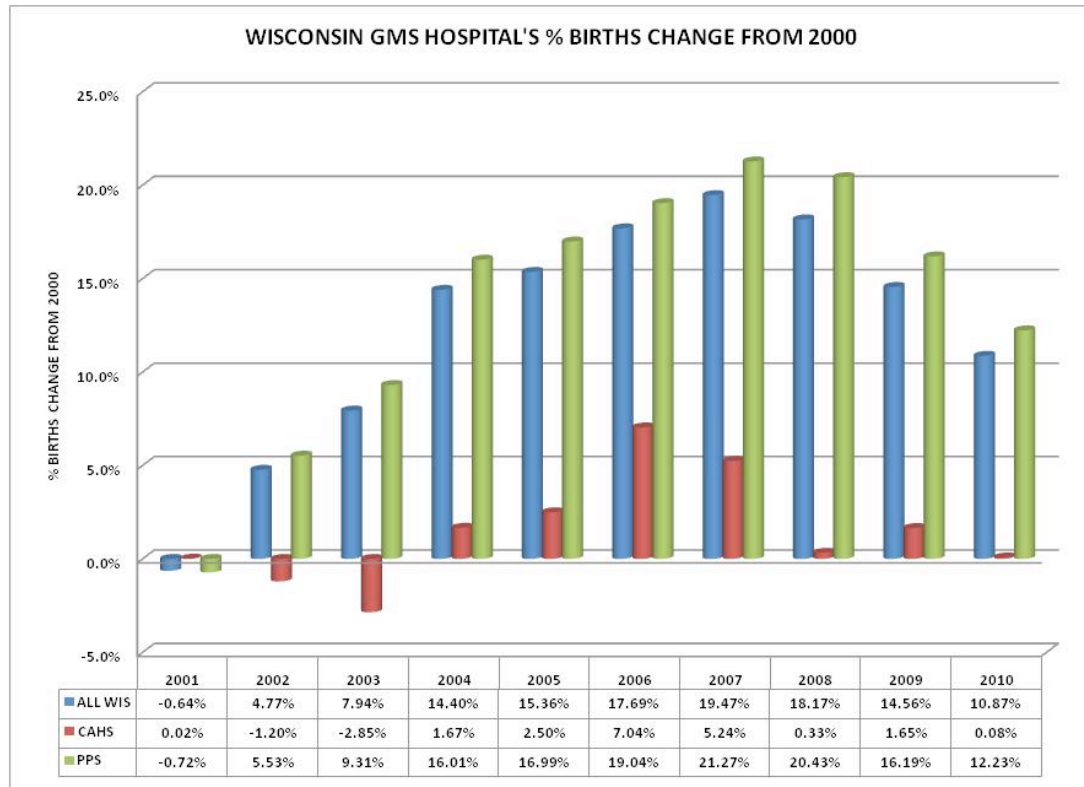
CAH's inpatient days (excluding Swing Bed and Newborn Days), have decreased over 26% from 2000 to 2010. Inpatient days increased for PPS facilities over the same period by 7.64%.



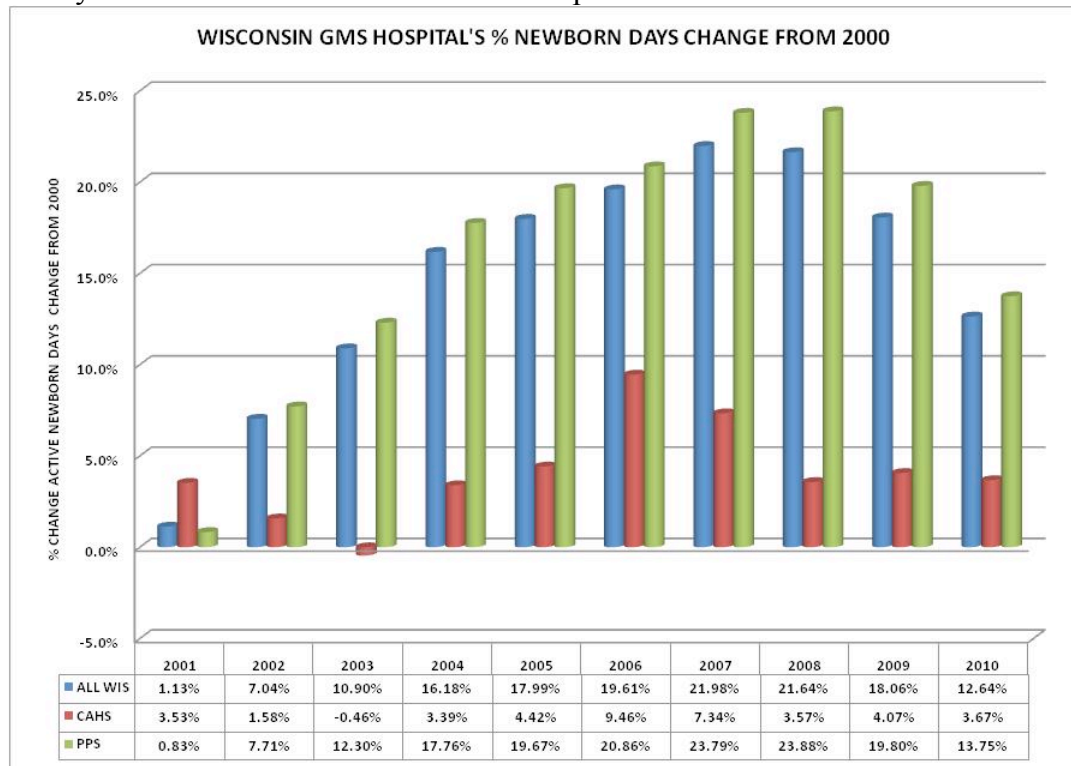
The number of surgical procedures for CAHs has increased by almost 15% since 2000 while the number of surgical procedures for PPS facilities increased by over 55%.



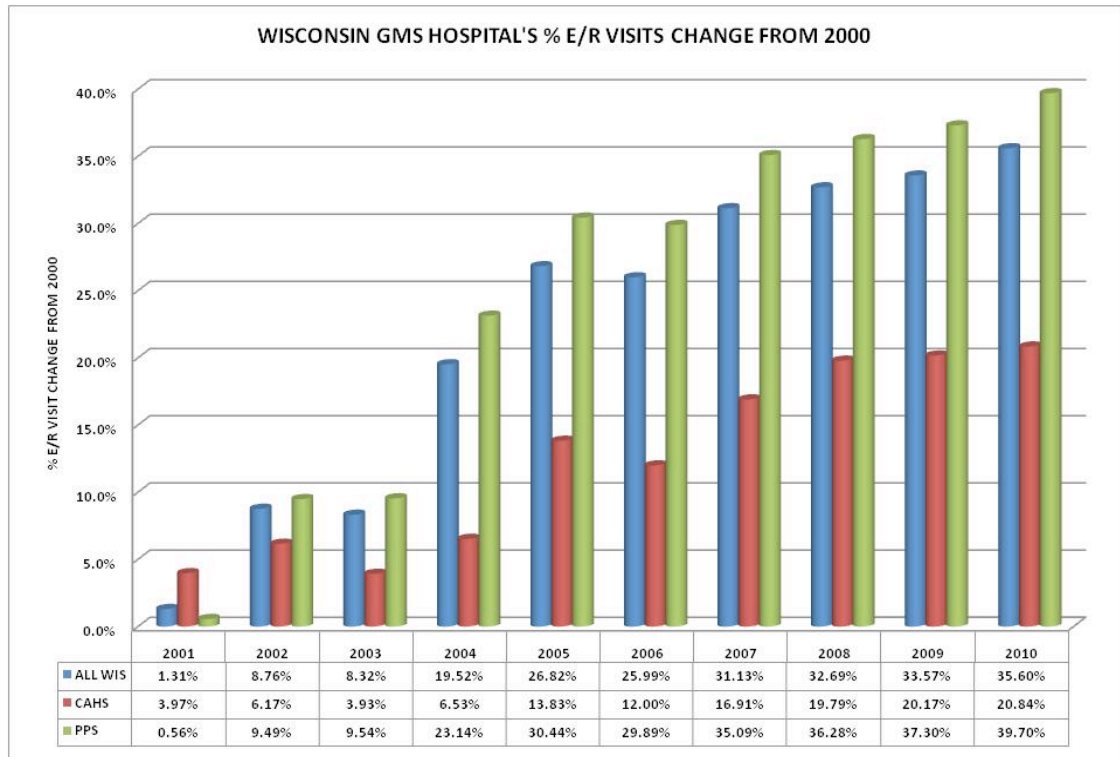
The number of births at CAHs has remained relatively unchanged since 2000 while the number of births for PPS facilities increased by over 10%.



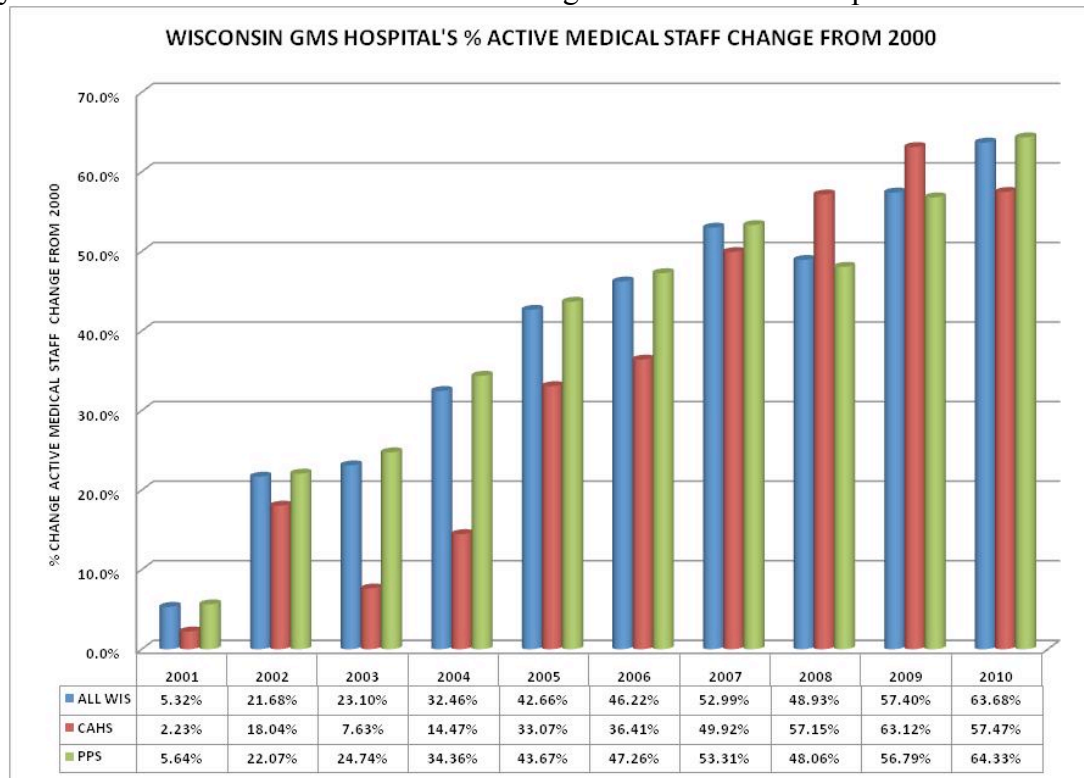
The % change in Newborn Days at CAHs from 2000 to 2010 is 3.67%. The % change in Newborn Days at PPS facilities over the same time period is 13.75%.



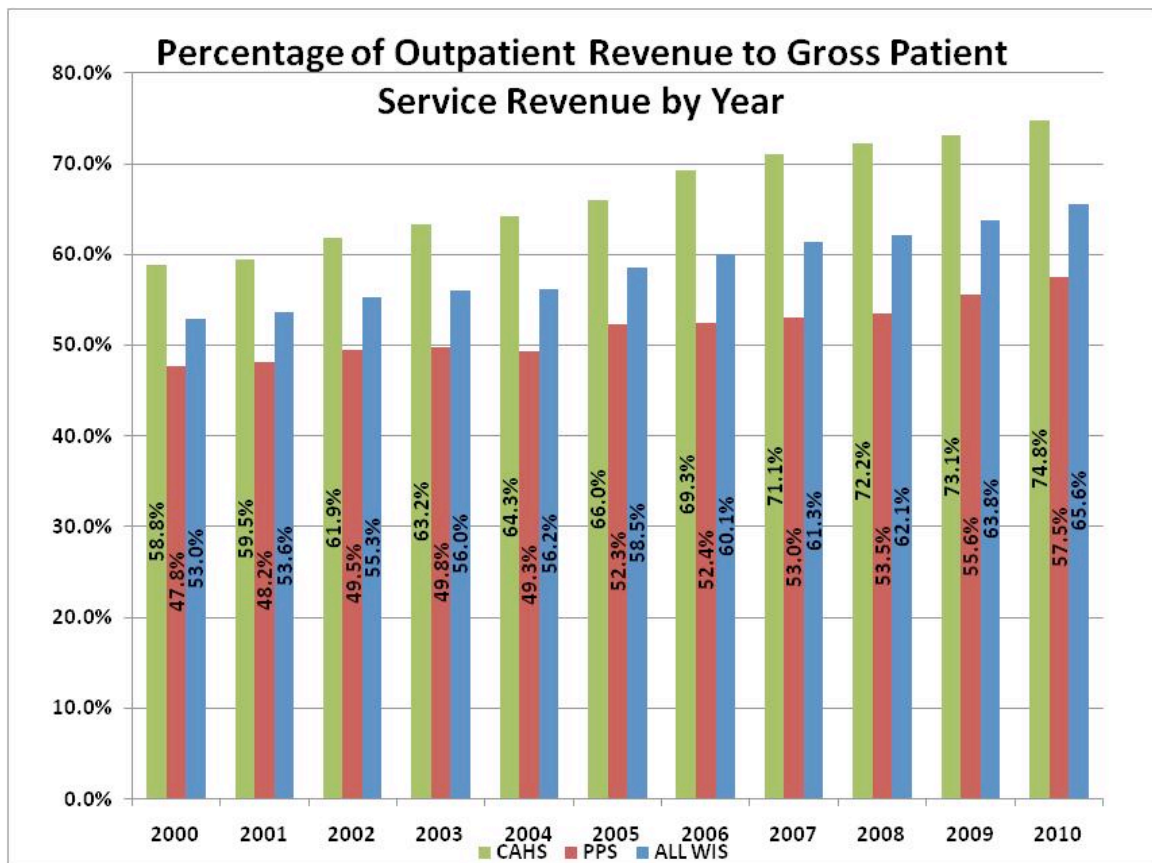
The % change in Emergency Room visits for PPS facilities from 2000 to 2010 is almost 40%. CAHs showed a % change over the same time period of almost 21%.

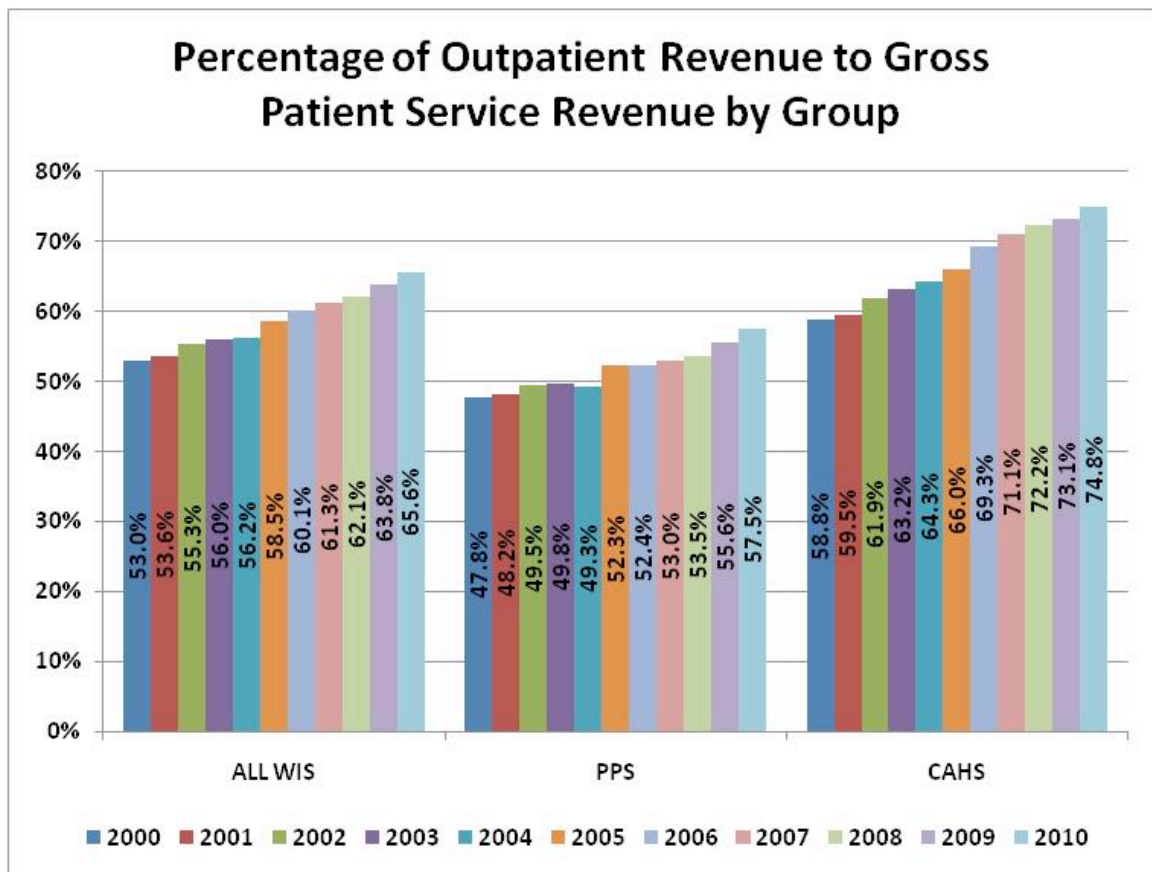


The % change in the number of Active Medical Staff for PPS facilities from 2000 to 2010 is slightly more than 64%. CAH's showed a % change over the same time period of about 57%.



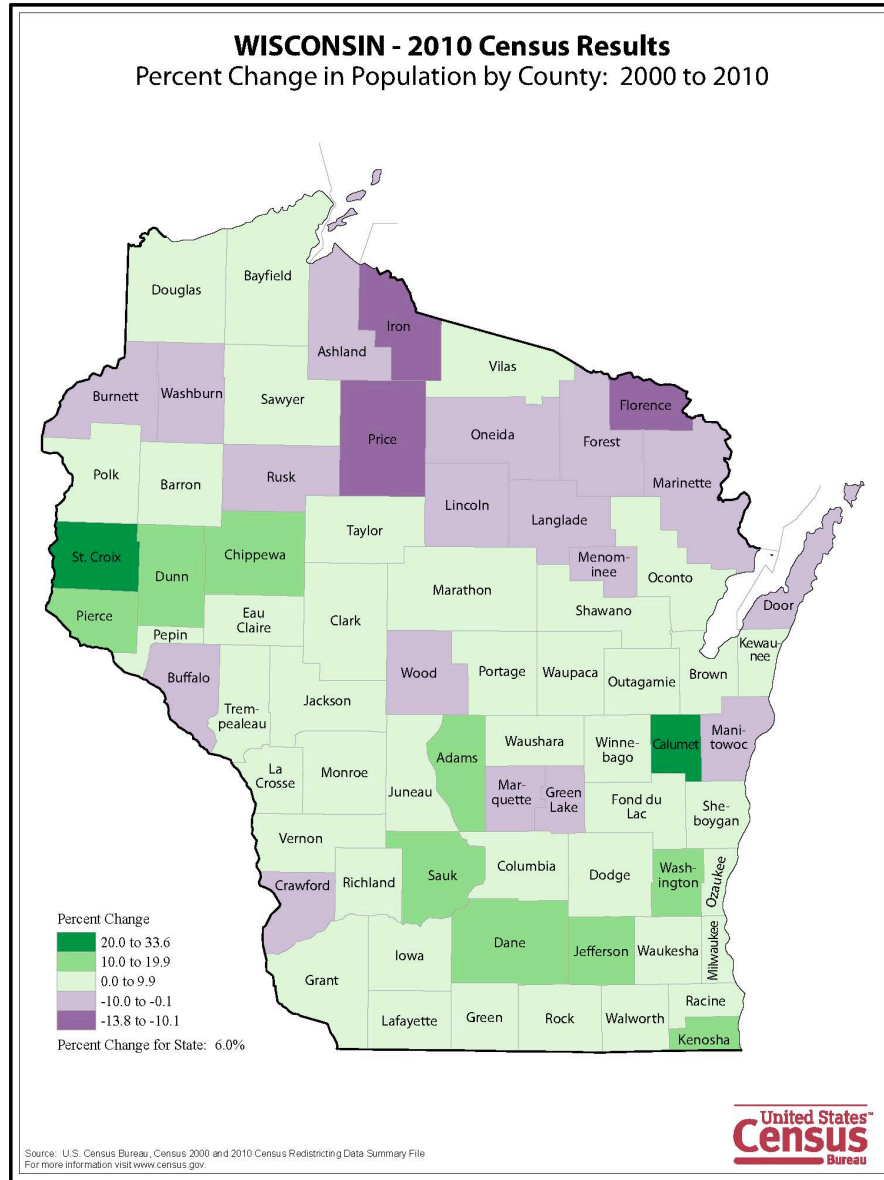
The Utilization graphs show a decline for the CAH facilities over the 10 years for key statistics like Patient Days. Some of the decrease in Patient Days can be attributed to the CAH rules regarding the 96 hour length-of-stay rule and the 25-bed limitation. However, even services that have increased like Surgical Procedures and Emergency Room Visits have not kept pace with the increased volumes at PPS facilities. Hospital utilization is impacted by the ability to attract and retain medical staff. On a positive note, the above Active Medical Staff graph shows CAH's only slightly behind PPS facilities in the increase in Medical staff from 2000 through 2010 (57% to 64%). Another reason that explains why CAH's are experiencing a higher drop in inpatient activity than PPS hospitals is the shift to outpatient services. As the following charts show, CAH's have consistently a much higher percentage of revenue from outpatient services than their PPS counterparts.





POPULATION CHANGES

The United States Census Bureau has recently completed and released the 2010 census. The census is one factor that helps us to understand the previously discussed utilization charts. Total population for Wisconsin increased from 2000 to 2010 by 6.0%. The following chart shows the change in population by Wisconsin counties between 2000 and 2010.



The map shows that for many counties in Wisconsin, the 2010 population has decreased or increased only slightly. Most counties where CAH's are located experienced similar population changes. Exceptions are Calumet, Sauk, and St. Croix counties. These counties are adjacent to large urban areas.

QUALITY MEASUREMENTS

Quality improvement and measurement remains a top priority for hospitals. The challenge for the healthcare industry over the next several years is how to improve quality while reducing costs.

In December 2002, CMS announced a partnership with several collaborators intended to promote hospital quality improvement and public reporting of hospital quality information. In July 2003, CMS began the National Voluntary Hospital Reporting Initiative. This initiative is now known as the Hospital Quality Alliance: Improving Care through Information, which is a public-private collaboration to improve the quality of care provided by the nation's hospitals by measuring and publicly reporting on that care. An important element of the collaboration, Hospital Compare, a website tool developed to publicly report credible and user-friendly information about the quality of care delivered in the nation's hospitals, debuted on April 1, 2005. Wisconsin hospitals participate in the WHA's CheckPoint program, which also makes quality data available to the public through a website. PPS Hospitals must submit quality data or receive a reduction in their Medicare payment update of 2.0 percentage points. Even though financial incentives such as those provided to PPS facilities have not been made available to CAHs, the availability of public reporting data may be required for CAHs to compete. For FY 2007, CMS required that hospitals submit data regarding 21 quality measures. The quality data collected included a number of infection-related measures and encompassed the following conditions: acute myocardial infarction, heart failure, pneumonia, and surgical care improvement. CMS collected a total of 44 quality measures for FY 2010, including: (1) 9 CMS-calculated AHRQ Patient Safety Indicators and Inpatient Quality Indicators and Composite Measures; (2) Participation in a Systematic Database for Cardiac Surgery; (3) Nursing Sensitive Measure on Failure to Rescue; and (5) 30-day Readmission Measures for Acute Myocardial Infarction and Pneumonia.

Another emerging trend in healthcare is value-based purchasing. Providers under this arrangement are rewarded for meeting pre-established targets for delivery of healthcare services. This is a fundamental change from fee for service payment. This payment model rewards physicians, hospitals, medical groups, and other healthcare providers for meeting certain performance measures for quality and efficiency. Some pilot studies have shown modest improvements in outcomes and efficiency. Some providers' are concerned that payment linked to outcome improvements may lead to avoidance of high-risk patients.

CMS is making a major push to reduce healthcare services provided due to hospital acquired conditions (HAC). HAC are serious conditions that patients may get during an inpatient hospital stay. If hospitals follow proper procedures, patients are less likely to get these conditions. Neither Medicare nor the patient will pay for treatment of these conditions. Medicare will pay for these conditions if the patient already had them when they were admitted to the hospital. The HACs that will be reported on Hospital Compare include:

- Objects Accidentally Left in the Body After Surgery (Foreign Object Retained After Surgery)
- Air Bubble in the Blood Stream (Air Embolism)
- Mismatched Blood Types (Blood Incompatibility)
- Severe Pressure Sores (Pressure Ulcer Stages III & IV)
- Falls and Injuries (Falls and Trauma (Includes: Fracture Dislocation Intracranial Injury Crushing Injury Burn Electric Shock))
- Vascular Catheter-Associated Infection
- Catheter-Associated Urinary Tract Infection (UTI)
- Signs of Uncontrolled Blood Sugar (Manifestations of Poor Glycemic Control)

The Patient Protection and Affordable Care Act (PPACA), discussed in the “Recent Legislation” section of this study, addresses the problem of high readmission rates. Beginning in FY 2013, PPS hospitals with higher-than-expected readmissions rates will experience decreased Medicare payments. Hospital performance will be evaluated based on the 30-day readmission measures for heart attack, heart failure and pneumonia that are currently part of the Medicare pay-for-reporting program and reported on Hospital Compare. PPACA requires CMS to modify the measures to exclude planned readmissions, as well readmissions that are unrelated to the first admission. CAH’s and post-acute care providers are excluded from the provisions. CMS will calculate hospitals’ actual readmission rates and compare them to hospitals’ expected readmission rates. Those hospitals with higher than expected readmission rates will be required to pay back to the Medicare program the payments they received for those readmissions deemed to be excessive. To recoup the money, CMS will determine an adjustment factor for each hospital with excessive readmissions that will decrease the hospital’s Medicare payment rate across all discharges. There is a ceiling as to how large the reduction can be. In FY 2013, the reduction cannot be greater than 1 percent. In FY 2014, it cannot be larger than 2 percent and in FY 2015 and beyond, it cannot be greater than 3 percent.

HEALTH INFORMATION TECHNOLOGY

The 2009 study discussed the American Recovery and Reinvestment Act of 2009 (ARRA). The major goal of ARRA is to modernize health care through the use of information technology. To drive adoption of electronic health records by 2015, the federal government is investing \$36 billion in Medicare and Medicaid providers. To receive an Electronic Health Record (EHR) incentive payment, the provider (eligible professional (EP), eligible hospital or CAH) must demonstrate meaningful use of certified EHR technology. CMS’ has established three stages of meaningful use criteria. The criteria for stage one, which begins in 2011, is:

- There will be 25 objectives/measures for EPs and 24 objectives/measures for eligible hospitals. The objectives/measures have been divided into a core set and menu set. EPs and eligible hospitals must meet all objectives/measures in the core set (15 for EPs and 14 for eligible hospitals).
- In 2011, EPs, eligible hospitals and CAHs seeking to demonstrate Meaningful Use are required to submit aggregate clinical quality measure numerator, denominator, and exclusion data to CMS or the States by attestation. In 2012, EPs, eligible hospitals and CAHs seeking to demonstrate meaningful use must electronically submit clinical quality measures selected by CMS directly to CMS (or the States) through certified EHR technology. CMS recognizes that for clinical quality reporting to become routine, the administrative burden of reporting must be reduced. By using certified EHR technology to report information on clinical quality measures electronically to a health information network, a State, CMS, or a registry, the burden on providers that are gathering the data and transmitting them will be greatly reduced.
- The burden of generating the necessary information for the provider to then use the information to improve health care quality, efficiency, and patient safety will also be reduced. CMS expects that by their second implementation year, States will have the capacity to accept direct submission of Medicaid providers’ clinical quality measures from certified EHR technology.

Stage 2 criteria are:

- Stage 2 would expand upon the Stage 1 criteria in the areas of disease management, clinical decision support, medication management support for patient access to their health information, transitions in care, quality measurement and research, and bi-directional communication with public health agencies. These changes will be reflected by a larger number of core objective requirements for Stage 2. CMS may also consider applying the criteria more broadly to the outpatient hospital settings (and not just the emergency department). Information exchange is a critical part of care coordination and we expect that the infrastructure will support greater requirements for using health information exchanges for Stage 2.

Stage 3 criteria are:

- Stage 3 would focus on achieving improvements in quality, safety and efficiency, focusing on decision support for national high priority conditions, patient access to self management tools, access to comprehensive patient data, and improving population health outcomes.

CMS has established the following dates for the incentive payment process:

- October 1, 2010 – Reporting year begins for eligible hospitals and CAHs.
- January 1, 2011 – Reporting year begins for eligible professionals.
- January 3, 2011 – Registration for the Medicare EHR Incentive Program begins.
- January 3, 2011 – For Medicaid providers, states may launch their programs if they so choose.
- April 18, 2011 – Attestation for the Medicare EHR Incentive Program begins.
- May 2011 – EHR Incentive Payments expected to begin.
- July 3, 2011 – Last day for eligible hospitals to begin their 90-day reporting period to demonstrate meaningful use for the Medicare EHR Incentive Program.
- September 30, 2011 – Last day of the federal fiscal year. Reporting year ends for eligible hospitals and CAHs.
- October 3, 2011 – Last day for eligible professionals to begin their 90-day reporting period for calendar year 2011 for the Medicare EHR Incentive Program.
- November 30, 2011 – Last day for eligible hospitals and critical access hospitals to register and attest to receive an Incentive Payment for Federal fiscal year (FY) 2011.
- December 31, 2011 – Reporting year ends for eligible professionals.
- February 29, 2012 – Last day for eligible professionals to register and attest to receive an Incentive Payment for calendar year (CY) 2011.

It is important for eligible providers to obtain meaningful use as soon as possible to avoid loss of incentive payments and avoid penalties. CAHs that are meaningful users by 2011 are eligible for four years of enhanced Medicare payments. Medicare payment reductions of 0.33% for non-users start in 2015 and increase to 1% in 2017.

RECENT LEGISLATION

At the time of the 2009 CAH study, major changes to our healthcare delivery system were being debated in Congress. As a result of this debate, the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148) was enacted March 23, 2010 and the related Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) was enacted March 30, 2010. Although it is beyond

the scope of this study to provide detailed analysis of this major legislation, a brief summary of some of the provisions follows:

Employer responsibilities: Employers are not required to provide health insurance coverage under the Affordable Care Act. However, automatic enrollment in health insurance plans sponsored by large employers is mandated. Employees may opt out of coverage. Effective in 2014, certain large employers that fail to offer minimum essential coverage will be liable for an additional tax. Employers with 50 or fewer employees are exempt from penalties.

Effective in 2014, employers that offer coverage will be required to provide a free choice voucher to employees with incomes less than 400 percent of the federal poverty level if their share of the premiums exceeds certain levels. Employers providing free choice vouchers will not be subject to penalties for employees that receive premium credits in the new state-based Exchange.

Individual responsibilities: Citizens and legal residents are required to have “qualifying health coverage.” Those without coverage pay a tax penalty, although exemptions will be granted for those for whom the lowest cost plan option exceeds 8 percent of an individual’s income, and those with incomes below the tax filing threshold. This requirement is being contested in several lawsuits. So far, some courts have ruled the law unconstitutional while some have ruled in favor of the individual responsibility requirement. Many legal analysts predict the constitutionality of this rule will ultimately be decided by the Supreme Court.

Health benefit exchanges: Effective in 2014, state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges are established through which individuals and small businesses with up to 100 employees can purchase qualified coverage. States are permitted to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017. States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area.

Individual and employer subsidies: Refundable and advance-able premium credits are made available to eligible individuals and families below certain income levels. Certain small employers are provided with a tax credit.

Benefit design: Effective in 2014, an essential health benefits package is established that provides a comprehensive set of services, limits annual cost-sharing to the current law HSA limits, and is not more extensive than the typical employer plan. Abortion coverage is prohibited from being required as part of the essential health benefits package.

Private coverage: Effective within 90 days of enactment and extending through January 1, 2014, a temporary national high-risk pool is established to provide health coverage to individuals with pre-existing medical conditions. In 2010, health insurance plans are required to report the proportion of premium dollars spent on clinical services, quality, and other costs. A process is established for reviewing increases in health plan premiums and requiring plans to justify increases. Six months after enactment, all individual and group policies must provide dependent coverage for children to age 26; individual and group health plans are prohibited from placing lifetime limits on the dollar value of coverage; insurers are prohibited from rescinding coverage except in cases of fraud; and plans are prohibited from imposing pre-existing condition exclusions

for children. Effective in 2014, waiting periods for coverage are limited to 90 days, and states have the option of merging the individual and small group markets.

Financing: The Congressional Budget Office estimates the cost of the coverage components of the reconciliation bill in combination with the Patient Protection and Affordable Care Act to be \$940 billion over ten years. These costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees, including an excise tax on high-cost insurance, which CBO estimates will raise \$32 billion over ten years. Beginning in 2014, a tax on individuals without qualifying coverage is imposed. Effective in 2018, an excise tax is imposed on insurers of employer-sponsored high-cost health plans with aggregate values that exceed \$10,200 for individual coverage and \$27,500 for family coverage. CBO estimates the proposal will reduce the deficit by \$143 billion over ten years.

Medicare and Medicaid: The Affordable Care Act, as amended by the Reconciliation Act, adds several provisions related to the link between quality outcomes and payments under Medicare. It also adjusts reimbursement for most types of Medicare providers to improve payment accuracy. It adjusts Medicare Advantage payments to be more in line with Medicare fee-for-service payments. The new laws make a variety of changes in Medicare Part D, including an attempt to close the “donut hole” for prescription drug coverage. The Affordable Care Act expands both access to Medicaid, as well as the types of services that are covered under Medicaid, including preventive services and long-term care. Additional revenue is allocated for specific maternal and child health services. Provisions to increase the program integrity of both Medicare and Medicaid are also included.

Medicare Part A: The Affordable Care Act establishes a value-based purchasing program for hospitals starting in 2013. A portion of a hospital’s Medicare payment will be linked to the hospital’s performance on quality measures related to common and high-cost conditions, such as cardiac, surgical, and pneumonia care.

Medicare Part B: The Physician Quality Reporting Initiative, which provides financial incentives to physicians who report quality data to CMS, will be extended through 2014. The Affordable Care Act also provides coverage, with no co-payment or deductible, for an annual wellness visit and personalized prevention plan services. It also will waive beneficiary coinsurance requirements for most preventive services.

Medicare Part C: The Affordable Care Act sets Medicare Advantage (MA) payments based on the average of the bids from MA plans in each market, rather than on a statutorily set benchmark rate. MA plans will be prohibited from charging beneficiaries cost-sharing that is greater than what is charged under Medicare fee-for-service. The Reconciliation Act requires MA plans to spend at least 85 percent of revenue on medical costs or activities that improve quality of care, rather than profit and overhead.

Medicare Part D: The Affordable Care Act, as amended by the Reconciliation Act, requires drug manufacturers to provide a 50 percent discount to Part D beneficiaries for brand-name drugs and biologics purchased during the coverage gap, or “donut hole” beginning July 1, 2011. The initial coverage limit in the standard Part D benefit will be increased by \$500 for 2010. Drug manufacturers are required to provide a 75 percent discount on brand-name and generic drugs by 2020. All Part D enrollees who enter the donut hole in 2010 would receive a \$250 rebate.

Medicaid: States will have the option starting in 2014 to expand Medicaid eligibility to non-elderly, non-pregnant individuals who are not otherwise eligible for Medicaid. States are required to maintain income eligibility levels for the Children's Health Insurance Program (CHIP) through the end of fiscal year 2019. Individuals may apply for or enroll in Medicaid or an insurance plan offered by one of the new state-based Exchanges. Hospitals are allowed to provide Medicaid services during a period of presumptive eligibility of all Medicaid eligibility categories.

Program integrity: Physician-owned hospitals that did not have a provider agreement prior to February 1, 2010, are prohibited from participating in Medicare. The Reconciliation Act changes the date from August 1, 2010, to December 31, 2010, after which physician ownership of hospitals to which they self-refer is prohibited. Beginning January 2010, the maximum period for submission of Medicare claims is reduced to not more than 12 months. The recovery audit contractor program (see Recovery Audit Contractor discussion in this study) is expanded to state Medicaid programs. Medicare prepayment medical review limitations are streamlined. The Department of Health and Human Services is required to maintain a national health care fraud and abuse data collection program for reporting specific adverse actions taken against health care providers, suppliers, and practitioners.

Additional Outpatient Reimbursement for Rural PPS Hospitals: The outpatient hold harmless provision provided for additional Medicare outpatient reimbursement to certain rural hospitals through calendar year 2010. Both rural hospitals with 100 or fewer beds that are sole community hospitals and rural hospitals with 100 or few beds that are not sole community hospitals are affected by this extension.

Rural Laboratory Test Payment Increase Reinstatement: Total payment for all reasonable costs of clinical diagnostic laboratory tests covered under Medicare Part B in rural hospitals with fewer than 50 beds that are located in qualified rural areas is reinstated.

Accountable Care Organizations: Accountable care organizations (ACO) are networks of doctors and hospitals that share responsibility for providing care to patients. In the new law, an ACO would agree to manage all of the health care needs of a minimum of 5,000 Medicare beneficiaries for at least three years. An ACO would bring together the different component parts of care for the patient – primary care, specialists, hospitals, home health care, etc. – and ensure they all work together to provide efficient, quality care. The new law establishes pilot ACO's to determine if they can deliver high-quality healthcare more efficiently than the current fee-for-service marketplace. ACOs providers would get paid more for keeping their patients healthy. Because of the leverage of high volumes, one concern is that ACO's in rural markets could dominate providers in a particular geographic area. It will take time to set up ACO's and to evaluate the pilot projects. Small rural providers may wish to utilize this time to evaluate their relationships with potential ACO partners. At the very least, CAH's should be actively participating in ACO rule making and implementation.

TRADITIONAL GOVERNMENT PROGRAM UTILIZATION

During the last decade, traditional or fee-for-service government program utilization of Wisconsin hospitals has declined. Table 8 shows traditional Medicare and Medicaid utilization based on program revenue to total revenue has declined for Wisconsin hospitals from just under 50%

(49.6%) in 2000 to 41.6% in 2010. PPS facilities declined by about 6% while CAH's decreased by 10.5% during this time period. The decrease in total program utilization is due to the decline in Medicare utilization. Traditional Medicaid utilization has increase slightly for both groups.

Table 8 Government Program Utilization Based On Revenue

	YEAR										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
MEDICARE UTILIZATION*											
ALL WIS	44.8%	43.7%	43.3%	42.5%	41.8%	41.6%	40.8%	38.5%	37.2%	36.3%	35.2%
PPS	42.1%	40.7%	41.2%	40.6%	39.5%	39.6%	39.2%	37.3%	36.3%	35.0%	34.5%
CAH	47.8%	46.9%	45.6%	44.7%	44.6%	44.0%	42.6%	39.8%	38.2%	37.7%	36.0%
MEDICAID UTILIZATION*											
ALL WIS	4.9%	5.6%	6.5%	6.8%	7.8%	7.6%	7.0%	7.1%	6.8%	6.3%	6.4%
PPS	4.6%	5.5%	6.2%	6.6%	7.7%	7.5%	6.7%	6.6%	6.4%	5.6%	6.2%
CAH	5.2%	5.6%	6.8%	7.1%	7.9%	7.8%	7.4%	7.7%	7.3%	7.0%	6.5%
TOTAL GOV. PROGRAM UTILIZATION*											
ALL WIS	49.6%	49.2%	49.7%	49.3%	49.6%	49.2%	47.8%	45.6%	43.9%	42.5%	41.6%
PPS	46.7%	46.2%	47.4%	47.1%	47.2%	47.1%	45.9%	43.9%	42.6%	40.6%	40.8%
CAH	53.0%	52.5%	52.4%	51.8%	52.4%	51.8%	50.1%	47.5%	45.5%	44.7%	42.5%
*BASED ON PROGRAM REVENUE/TOTAL REVENUE											

The decrease in total government payer utilization (traditional Medicare and Medicaid) has been offset partly due to the increase in Medicaid utilization. However, as Table 8 indicates, traditional Medicare revenue as a percent of total revenue has declined. One reason for this decline may be because of the increased beneficiary participation in the private Medicare Advantage plans. The Medicare Advantage program creates opportunities for increased access and services to Medicare beneficiaries, but private plan reimbursement is based on the contractual relationship between the plan and the provider. Depending on the terms of the contract, private plan growth may create major reimbursement problems for CAH providers. Medicare Advantage penetration (see Table 9 below) indicates that over 30% of Wisconsin Medicare beneficiaries are now members of private plans.

Table 9 Wisconsin vs. National Medicare Advantage Plan Penetration

MEDICARE ADVANTAGE PLAN PENETRATION*												
	YEAR											
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
US	16.8%	15.0%	13.2%	12.2%	12.1%	12.7%	16.3%	19.0%	21.0%	22.5%	23.6%	25.6%
WI	5.1%	5.0%	2.6%	3.1%	4.7%	7.0%	15.0%	20.4%	23.3%	26.1%	29.0%	30.1%
*Penetration % is number of Medicare Advantage Enrollees/Medicare Beneficiaries												
SOURCE: KAISER FAMILY FOUNDATION												

As this trend continues, problems for hospitals in identification of Medicare Advantage patients, billing, and reimbursement escalate. Private Fee-for-Service (PFFS) plans are a particular problem for rural facilities. Rural facilities lack negotiating power and therefore are at a disadvantage when negotiating contracts with Medicare Advantage plans. CAHs are experiencing changes in Medicare Advantage utilization of services, especially swing-beds. Because of the retrospective nature of CAH traditional Medicare payment, some Medicare Advantage plans continue to struggle to pay providers correctly. As Medicare Advantage plans continue to grow, CAH's cost-based payment gains under traditional Medicare may be at risk.

MEDICARE RECOVERY AUDIT CONTRACTOR (RAC)

As discussed in the 2009 study, the Medicare Recovery Audit Contractor (RAC) program was established as a demonstration program to identify improper Medicare payments by the Medicare Modernization Act of 2003. RACs are paid on a contingency fee basis, receiving a percentage of the improper overpayments and underpayments they collect from providers. According to a March, 2011 announcement from Center for Medicare and Medicaid Services (CMS), the RAC program succeeded in correcting more than \$184.6 million in Medicare improper payments for the January 2011 through March 2011 time period. The top issues for the RAC's include improper reporting of ventilator hours, billing incorrect principal and/or secondary diagnosis that results in a incorrect payment, and incorrectly billing for durable medical equipment, prosthetics, orthotics, and supplies. Providers can appeal the RAC determinations. The Affordable Care Act (see recent legislation) expanded the RAC program to state Medicaid programs. Programs to minimize fraud, abuse, and billing errors make it vital that hospitals properly code and bill for legitimate services.

UNCOMPENSATED CARE

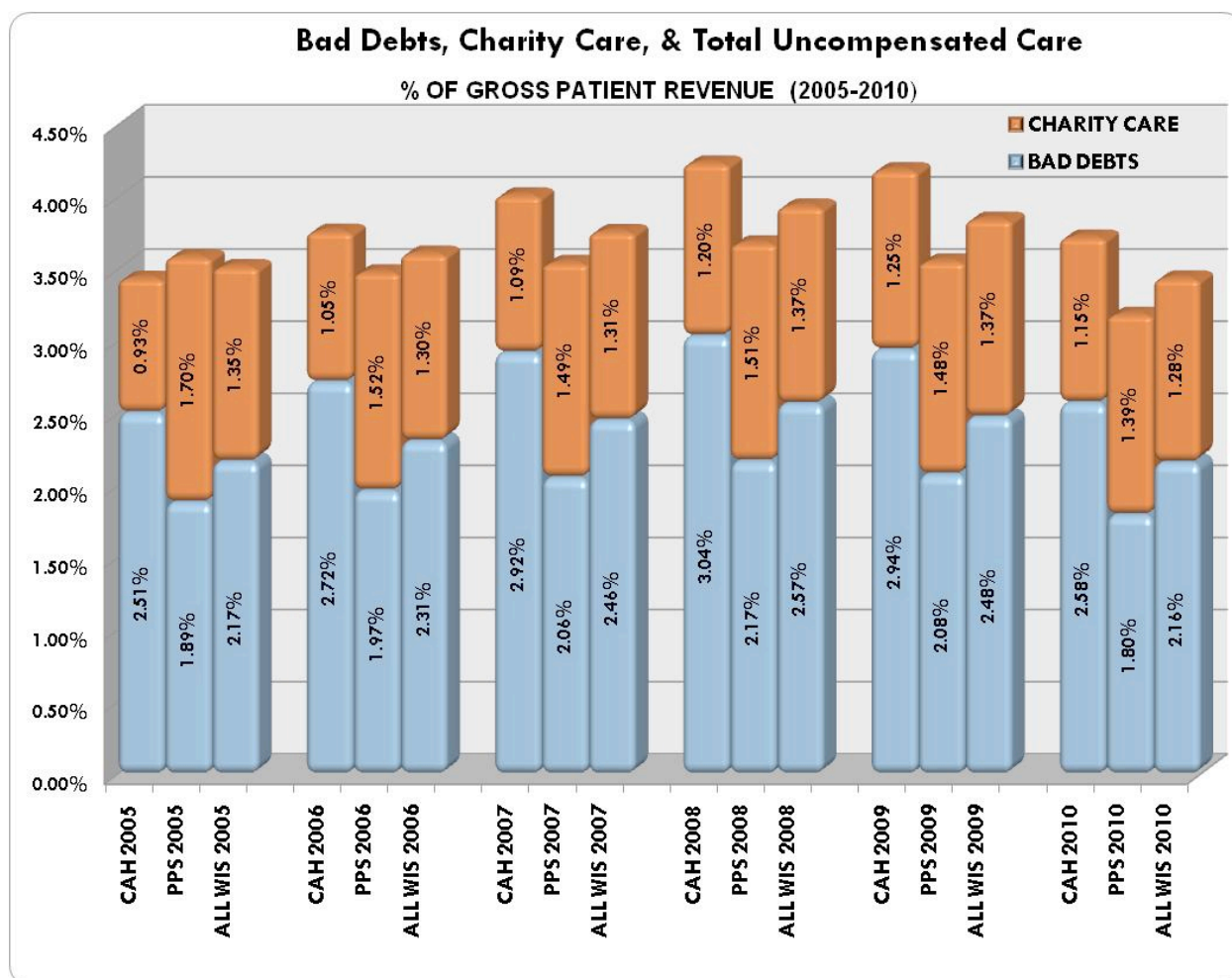
Uncompensated Care is defined as the total of Bad Debts and Charity Care (sometimes referred to as community care or indigent care). The term "uncompensated health care" is used to encompass charity care and bad debt. Both represent services for which the hospital does not receive payment. Charity care is care for which a hospital does not expect payment because the patient cannot afford to pay. Bad debt, however, is care for which payment is expected, but the hospital is unable to collect. Distinguishing charity care from bad debt has been complex because of the way

hospitals defined and reported these components for accounting purposes. For example, one hospital may write off charges as bad debt, while another hospital may call such charges charity care. In the past, some hospitals did not account separately for charity care and bad debts. The distinction, however, between charity care and bad debt is becoming even more important. The PPACA discussed in “Recent Legislation” requires non-profit hospitals to conduct community health needs assessments every three years and adopt an implementation strategy to meet the needs of the community identified through the assessment. This requirement is effective during tax years beginning after March 23, 2012. The assessment must include input from individuals who represent the broad interests of the community, including expertise in public health. Community health needs assessments may be conducted in collaboration with other hospitals or organizations. The assessment also must be made available to the public. One of the new requirements is that hospitals must implement a written financial assistance policy. The policy must include:

- Eligibility criteria for financial assistance, and whether the assistance includes free or discounted care.
- The basis for calculating the amounts charged to patients.
- The method for applying for financial assistance.
- For organizations that do not have a separate billing and collection policy, the actions the organization may take in the event of non-payment, including collection actions and reporting to credit agencies.

The financial assistance policy must be widely publicized within the community the organization serves. Another requirement is that hospitals must limit the amounts charged for care provided to individuals eligible for assistance under the organization’s financial assistance policy to no more than what is charged to individuals with insurance. Hospitals are not allowed to engage in extraordinary collection efforts against an individual until reasonable effort has been made to determine if the individual is eligible for assistance under the hospital’s financial assistance policy. Extraordinary collection efforts include lawsuits, liens on residences, arrests, body attachments, or other similar collection processes. Tax-exempt hospitals should review and their financial assistance policies to ensure that they meet these new requirements. Charity services are an important indicator of a hospital’s fulfillment of its charitable obligations.

The following graph is a stacked bar graph which shows the average Bad Debts and Charity Care % of Total Revenue for CAHs, PPS, and both groups combined from 2005 through 2010.



After a steady increase in the average uncompensated care from 2005 through 2008, both groups experienced a leveling off in 2009 and then a slight decline in 2010. Several factors may have contributed to this decrease. The numbers of patients who are uninsured or underinsured obviously affect Uncompensated Care. Another may be changes in health insurance plans that affect beneficiary deductibles and coinsurance. Coverage under tax-advantaged private plans, employer based plans, or government programs will also affect Uncompensated Care. One trend in the graph is that since 2006, CAH's provide higher levels of uncompensated care compared to the average for Wisconsin hospitals. The graph indicates this is a result of higher percentage of bad debts. The economic strength of the communities CAHs serve may contribute to the trend. In 2009, Uncompensated Care for both groups remained relatively flat. In 2010, Uncompensated Care actually decreased slightly for both groups.

SUMMARY

It was more than a decade ago that the first Wisconsin hospital obtained critical access status. This study includes 57 Wisconsin facilities or slightly less than half of all Wisconsin General Medical Surgical hospitals. This study, the fifth in a series of reports on the financial status of CAH hospitals, indicates several areas of improvement but also areas for concern. On the positive side, CAH's have shown improvement in several key financial ratios. Days Revenue in Accounts Receivable has decreased and as a result, Days Cash On Hand has increased from 2000. Operating and Total Margin ratios decreased in 2008, 2009, and 2010 from the highs in 2005, 2006, and 2007, but are still higher than 2000. The Financial Strength Index, a composite of four financial ratios, has improved from 2000. On the utilization side, CAH's outpatient revenue as a percentage of total revenue continues to increase faster than for PPS facilities. The percentage of CAH's that do not own and operate a Nursing Home has increased in the last decade. Also, a higher percentage of CAHs' do not provide Psychiatric, Alcoholism/Chemical Dependency inpatient care, Hospice, and Home Health care. The percentage of CAH's that own or operate a primary group practice has increased from 2000 as has the percentage of CAH's that are part of a health care system. There may be many reasons for the changes in services provided by CAH's. However, it would be reasonable to assume that CAH management, along with their Board of Directors and Medical Staff's, have considered the financial impact of deciding what services to provide.

An area of concern is the decreasing volumes for various inpatient services such as inpatient days and the slow rate of growth for births. The recent 2010 US Census indicates many counties with CAH facilities grew at a slower pace than many urban counties. The average age of the population in rural counties continues to climb indicating an aging population and the migration of younger workers to more populous areas for employment. The American Recovery and Reinvestment Act of 2009 (ARRA) will help CAH's fund some of their information technology needs. However, the 2010 Average Age of Plant ratio for CAH's was the highest it has been since 2000. Access to capital to upgrade aged facilities during weak economic times will be a challenge.

Because of patient and economic demographics in Wisconsin CAH communities, government program reimbursement will have a major impact on future financial performance. Over the next several years, both Federal and State governments will face continuing budget deficits. Cost reimbursement for inpatient, outpatient and swing bed services may help to insulate CAH's from the most severe funding cuts to government programs but as previously mentioned, not all government funded services CAH's provide are cost based.

Another major question mark for all providers is the impact of the recently passed Patient Protection and Affordable Care Act (PPACA) and the related Health Care and Education Reconciliation Act of 2010. Many of the details of this major legislation are still unknown. It is possible that future legislation will revise or possibly repeal this reform. In summary, we have answers but also many questions. No one can predict what the future holds. However, those who manage Wisconsin CAH's may wish to consider the following Latin Proverb: "If you make good use of the present time, you need not be apprehensive about the future."

OTHER RESOURCES

Here are several websites that have more information:

Administration on Aging www.aoa.gov

Agency for Healthcare Research and Quality www.ahrq.gov

American Hospital Association <http://www.aha.org/>

American Native American and Alaska Native Information <http://www.cms.hhs.gov/aian>

Centers for Medicare & Medicaid Services:

Medicare Learning Network <http://www.cms.hhs.gov/medlearn>

Rural Health Information <http://www.cms.hhs.gov/center/rural.asp>

Critical Access Hospital Information <http://www.cms.hhs.gov/center/cah.asp>

Federally Qualified Health Centers Information <http://www.cms.hhs.gov/center/fqhc.asp>

Electronic Health Record Incentive Program <http://www.cms.gov/ehrincentiveprograms/>

Affordable Care Act Information <http://www.cms.gov/Affordable-Care-Act/>

Health Resources and Services Administration www.hrsa.gov

Hospital Compare <http://www.hospitalcompare.hhs.gov/>

Native American Health Service www.ihs.gov

National Association of Community Health Centers www.nachc.org

National Rural Health Association www.nrharural.org

Rural Assistance Center <http://www.raonline.org/>

Rural Wisconsin Health Cooperative www.rwhc.com

United States Department of Agriculture www.usda.gov

Wisconsin Department of Health Services <http://dhfs.wisconsin.gov/>

Wisconsin Hospital Association <http://www.wha.org/>

Wisconsin Office of Rural Health <http://www.worh.org/>

Wisconsin PricePoint <http://www.wipricepoint.org/>

WHA Information Center <http://www.whainfocenter.com/>

WHA Checkpoint <http://www.wicheckpoint.org/index.aspx>

US Census Bureau <http://www.census.gov/>

US 2010 Census <http://2010.census.gov/2010census/>