

For the Wisconsin Office of Rural Health

The Financial Effects of Wisconsin Critical Access Hospital Conversion

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TABLE OF CONTENTS

EXECUTIVE SUMMARYiii

NUMBER OF CRITICAL ACCESS HOSPITALS IN THE U.S., 1999-2008.....iv

INTRODUCTION - 1 -

SCOPE OF STUDY - 1 -

REIMBURSEMENT METHODOLOGIES - 2 -

FINANCIAL PERFORMANCE ANALYSIS - 3 -

CHANGES IN SERVICES - 19 -

UTILIZATION - 25 -

CAPITAL FINANCING NEEDS..... - 27 -

MEDICARE RECOVERY AUDIT CONTRACTOR (RAC)..... - 28 -

QUALITY MEASUREMENTS - 28 -

HEALTH INFORMATION TECHNOLOGY..... - 29 -

RECENT LEGISLATION..... - 30 -

MEDICARE ADVANTAGE..... - 33 -

UNCOMPENSATED CARE - 34 -

FUTURE OF CRITICAL ACCESS HOSPITALS - 36 -

SUMMARY - 38 -

OTHER RESOURCES - 39 -

EXECUTIVE SUMMARY

One of the main objectives of the Critical Access Hospital (CAH) program was to improve the financial stability of small, rural facilities. These facilities were struggling with Medicare's Prospective Payment Systems (PPS). Medicare payments to these institutions were inadequate because they did not take into account low volumes and higher fixed costs. The financial deterioration of the hospitals resulted in a lack of capital investment. Some facilities closed. Lack of access to healthcare services became an issue in some areas. Currently, CAHs are paid 101% of their Medicare costs for inpatient services, outpatient services (including laboratory and therapy services), and post-acute services in swing beds. As a result, prior studies have shown that the CAH program has improved financial performance and access to capital.

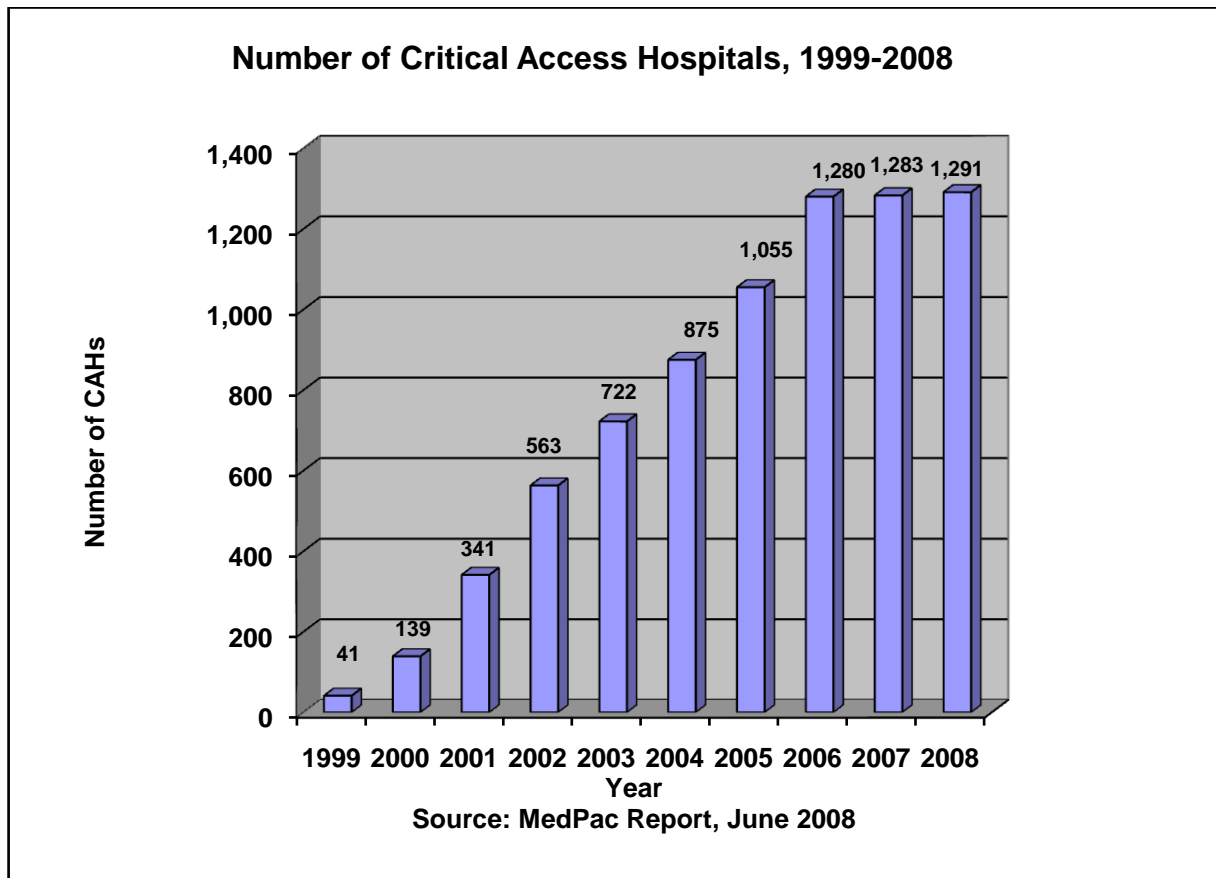
This study shows that:

- After a substantial increase in Total Margin from 2006 to 2007, the average Total Margin for both CAHs and PPS hospitals dropped in 2008 by about 4%.
- CAHs experienced lower Operating Margins than PPS hospitals in 2008.
- CAHs Average Age of Plant declined in 2008 but still is higher than PPS hospitals.
- Net Days in Accounts Receivable declined for both CAHs and PPS hospitals.
- Overall strength as measured by the Financial Strength Index decreased in 2008 for both CAHs and PPS hospitals, compared to 2007.
- CAHs are discontinuing services such as Nursing Homes, Alcohol/Chemical Dependency, and Psychiatric Units.
- Several key utilization statistics such as inpatient days, surgical operations, and emergency visits all showed less growth or more rapid decline in 2008 from 2007 for CAHs than experienced by all state hospitals.

The purpose of this study is to analyze the financial condition of Wisconsin's CAHs. This report updates previous studies completed in 2003, 2005, and 2007. There have been many changes in the healthcare industry since 2007. Changes in Federal and State government programs, increasing competition, consumer-driven transparency, quality measurement, and an economic downturn have happened since the last CAH study. This study will address the financial impact these events have had on Wisconsin's CAHs.

The number of CAHs nationally has grown steadily over the last ten years. As of March 2009, there were 1,291 CAHs in the United States (see following graph). According to the Centers for Medicare & Medicaid Services (CMS) along with information from state Flex Coordinators, on April 23, 2009, there were 1,302 CAHs. 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 most 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, barring unforeseen legislation, the number of CAHs should remain fairly constant.

Number of Critical Access Hospitals in the U.S., 1999-2008



Currently, Wisconsin has 59 CAHs which means in 2008 roughly 40% of all Wisconsin facilities were CAHs. 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 converted 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
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) converted to CAH status during 2002, 2003, and 2004. The remaining nine facilities converted in 2005, 2006, or 2007.

Financial and services data were analyzed for nine years (from 2000 through 2008). 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 their conversion date occurred 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

- Most graphs group together all 57 CAH study facilities, all PPS hospitals, and all Wisconsin hospitals. 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. Further discussion of the source of the study data can be found in the “Scope of Study” section.
- Even though CAHs have improved in some key financial performance ratios, the overall Financial Strength Index (FSI) as measured by a ratio that combines several key performance indicators (see further discussion in the Financial Performance section of this study), declined in 2008. The ratio also shows the group at the bottom of the “Good” range in the FSI Rating Guide (see Table 6).
- Many facilities have used their improved financial position to improve or replace outdated plants and equipment resulting in an improvement in the average age of plant ratio (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 and 2007.

This report will show that:

- After a substantial increase in Total Margin from 2006 to 2007, CAHs Total Margin dropped in 2008 by about 4%. Both PPS and All Wisconsin groups experienced a similar decrease.
- CAHs experienced lower Operating Margins than both PPS and All Wisconsin groups in 2008.
- CAHs Average Age of Plant declined in 2008 but still is higher than PPS and All Wisconsin groups.
- Net Days in Accounts Receivable declined for CAHs, PPS, and All Wisconsin groups.
- Overall strength as measured by the FSI decreased for all groups in 2008 from 2007.
- CAHs are discontinuing services such as Nursing Homes, Alcohol/Chemical Dependency, and Psychiatric Units.

SCOPE OF STUDY

As of August, 2009, 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.

Prior studies have used a combination of publicly available information as well as internal data. Financial data was taken basically from the CMS Healthcare Cost Report Information System (HCRIS). Although the HCRIS database has useful cost report information, it also has some serious shortcomings for financial studies. For example:

- The cost report G-Series is generally designed to report the hospital's balance sheet and income statements. However, providers have some flexibility on where to report data which leads to inconsistency in the analysis.
- The G-series total expense must agree to Worksheet A because of the edits in Medicare-approved cost report software. However, total Worksheet A expenses many times, because of non-reimbursable financial expenses such as Bad Debts, will not agree with the providers income statement. There may also be differences in the financial statements grouping of operating and non-operating expenses vs. Worksheet A.

- Generally, providers must file cost reports 5 months after the end of their fiscal years. It also will be several months before the cost report is reviewed and appears in the HCRIS database which delays the availability of the information.

Because of these data issues, 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 2009 study data is the Fiscal and Annual Survey. The years included in this study are from 2000 through 2008. 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. One recent minor change to CAH reimbursement included in Section 148 of the Medicare Improvements for Patients and Providers Act (MIPPA), effective for services furnished on or after July 1, 2009, a CAH will be paid 101% of reasonable cost for outpatient clinical diagnostic laboratory tests even if the patient for whom these services are billed was not physically present in the CAH at the time the specimen is collected. In such cases, the CAH will receive 101% of reasonable cost for the outpatient clinical diagnostic laboratory test as long as the patient is an outpatient of the CAH and is receiving services directly from the CAH. For purposes of section 148, the patient is considered to be receiving services directly from the CAH if either one of the following qualifications is met: 1) The patient receives outpatient services in the CAH on the same day the specimen is collected, or 2) The specimen is collected by an employee of the CAH. If the patient is physically present in the CAH or a facility that is provider based to the CAH at the time the specimen is collected, neither of the above two conditions need to be met. Prior to this change, these services were paid under the Clinical Laboratory Fee Schedule. MIPPA is also discussed in the "Recent Legislation" section of this study.

The Wisconsin Medical Assistance Program (Medicaid) also reimburses CAHs based on costs. Although this is generally an improvement over the prospective system that the Wisconsin program uses for other hospitals, State budget problems have slowed Medicaid CAH final settlements.

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 & 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: FSI Dimensions & 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.

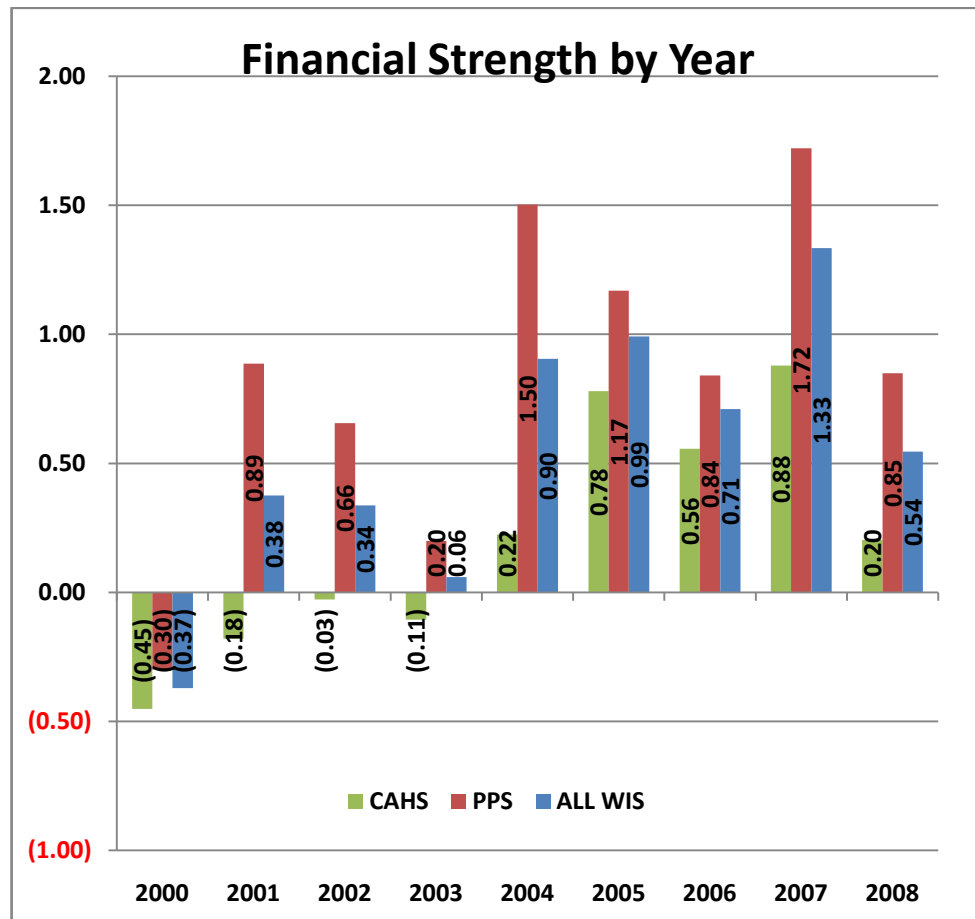
Table 6: FSI Rating Guide

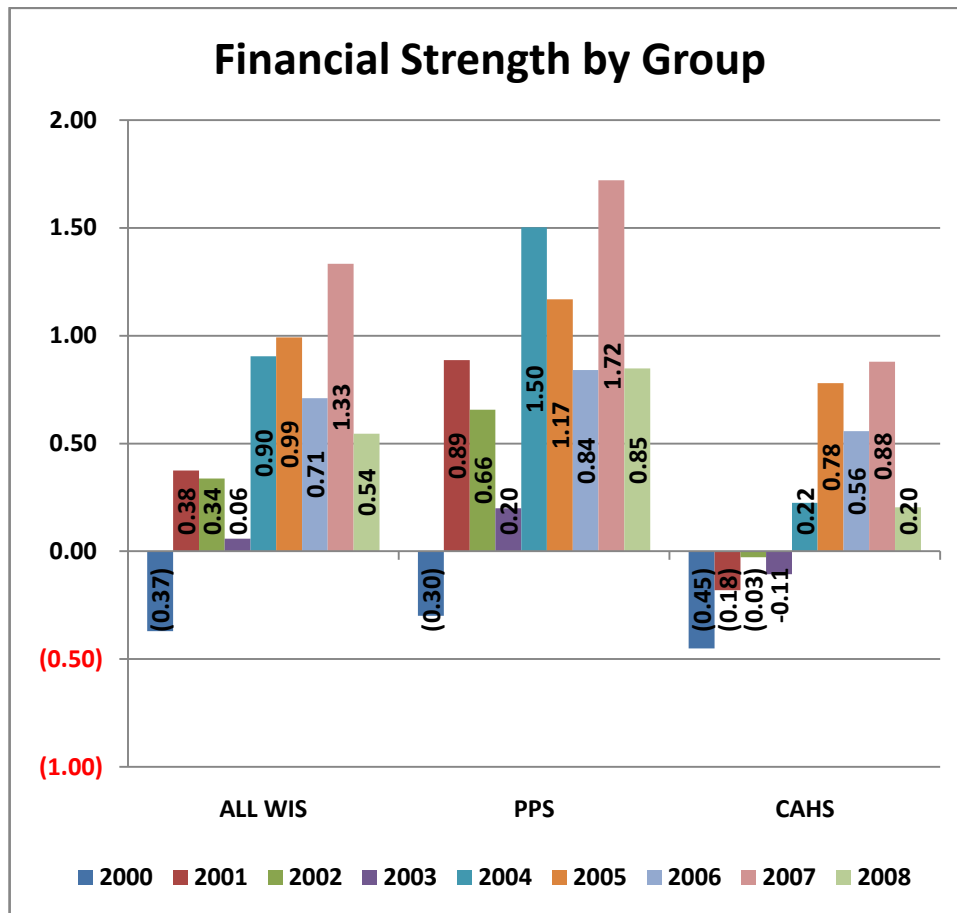
Score	Financial Health
Greater than 3	Excellent
0 to 3	Good
-2 to 0	Fair
Less than -2	Poor

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 increasing trend in the FSI for CAHs. The following graphs show after peaking in 2007, CAH’s FSI dropped in 2008. This same trend was experienced by the PPS and All Wisconsin groups. The FSI for PPS and All Wisconsin groups continue to be higher than for CAHs.

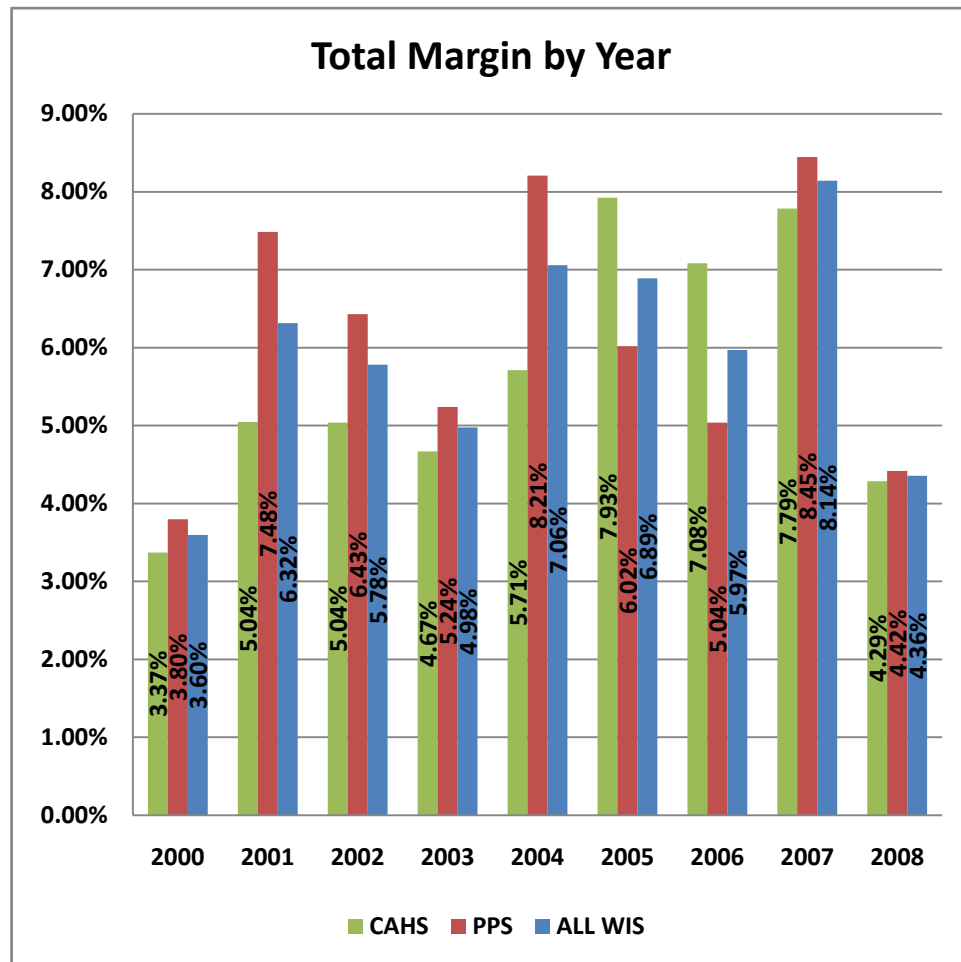
¹ SOURCE: “The Financial Strength Index: A Measure of a Firm’s Overall Financial Health,” by William O. Cleverley, Ph.D., President, Cleverley & Associates, and Andrew E. Cameron, Ph.D., MBA, Assistant Professor, Ohio State University. Published in the January 2003 issue of HFMA’s newsletter, *Executive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

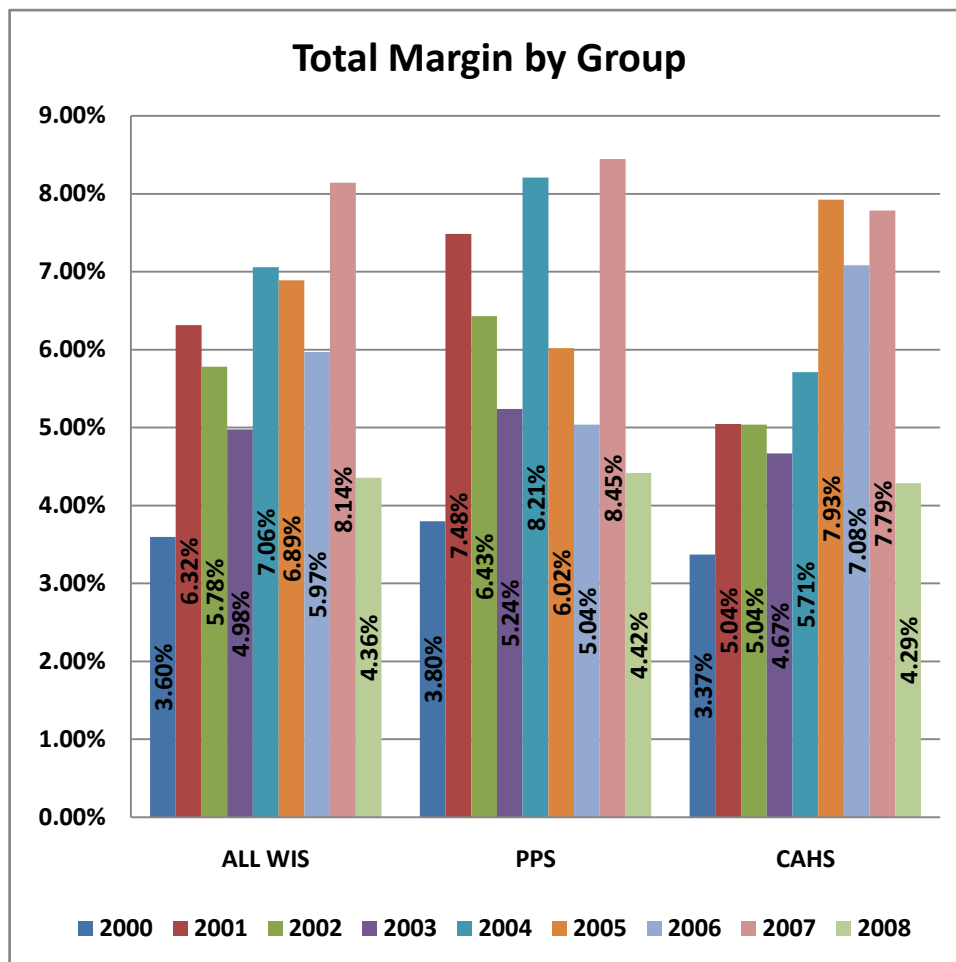




TOTAL MARGIN

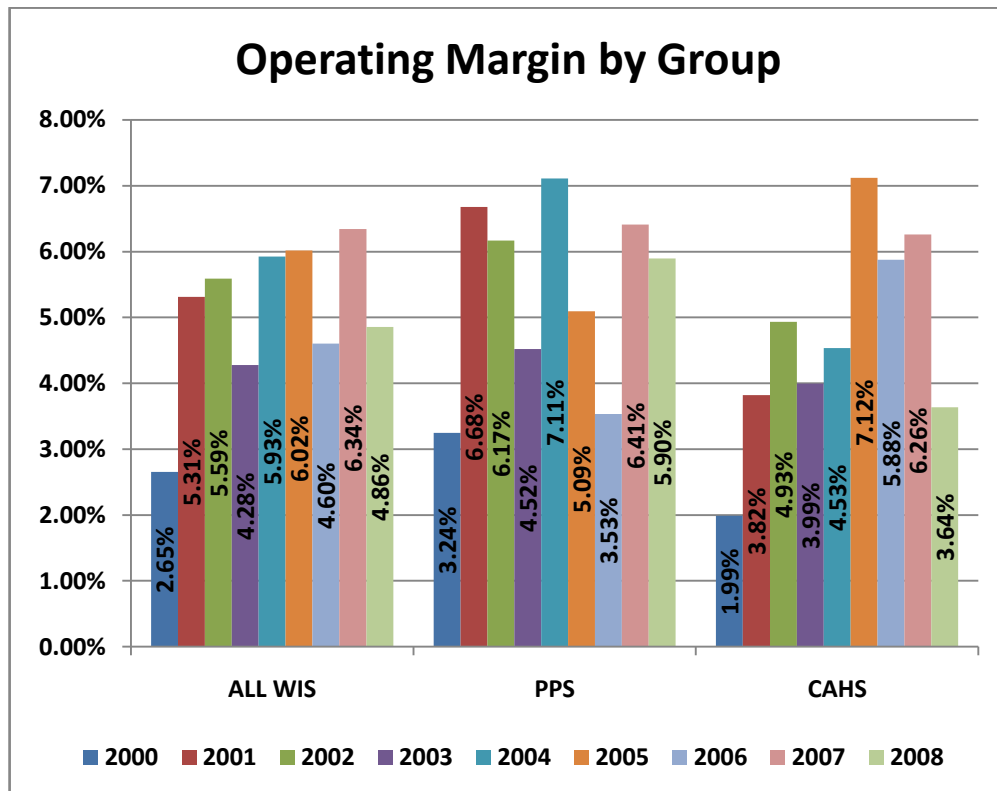
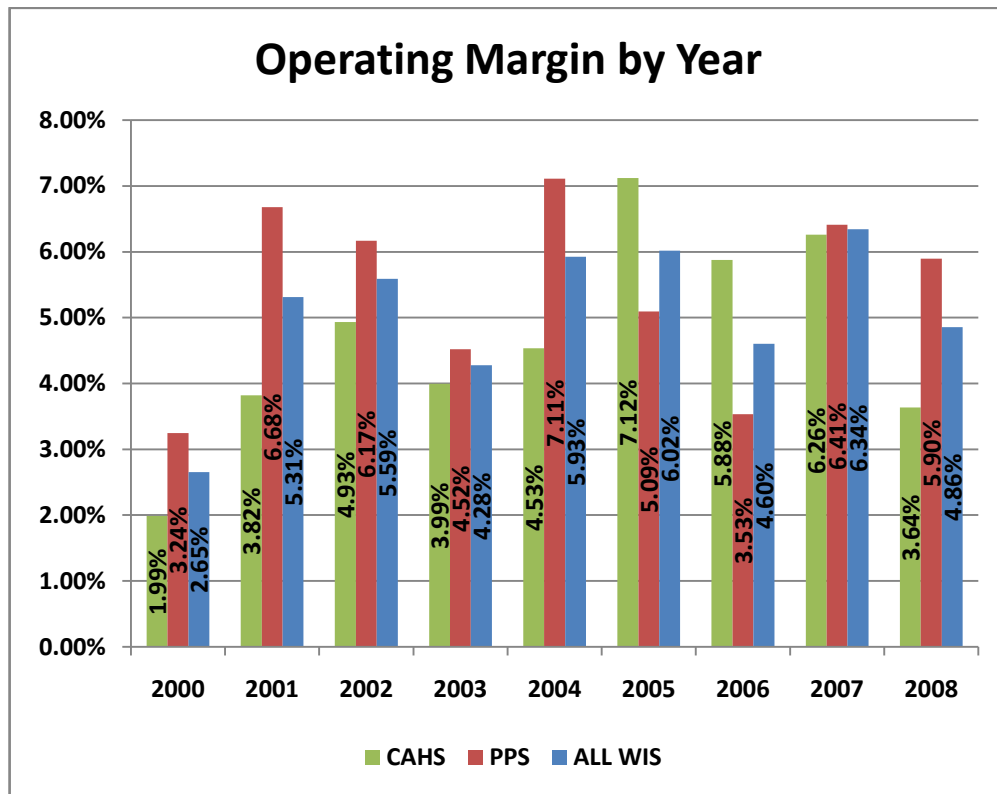
As indicated in Table 4, Total Margin represents the percent of Net Income to Net Patient Revenue. Total Margin ratio includes both operating and non-operating income. Increasing trends are favorable financial indicators. From 2000 through 2004, CAHs Total Margin lagged behind PPS and All Wisconsin. In 2005 and 2006, CAHs improved to the point it had the highest of the three groups. In 2007, CAHs fell slightly below PPS and All Wisconsin but all three groups had Total Margins of approximately 8%. In 2008, Total Margin for all groups fell by approximately 4%.





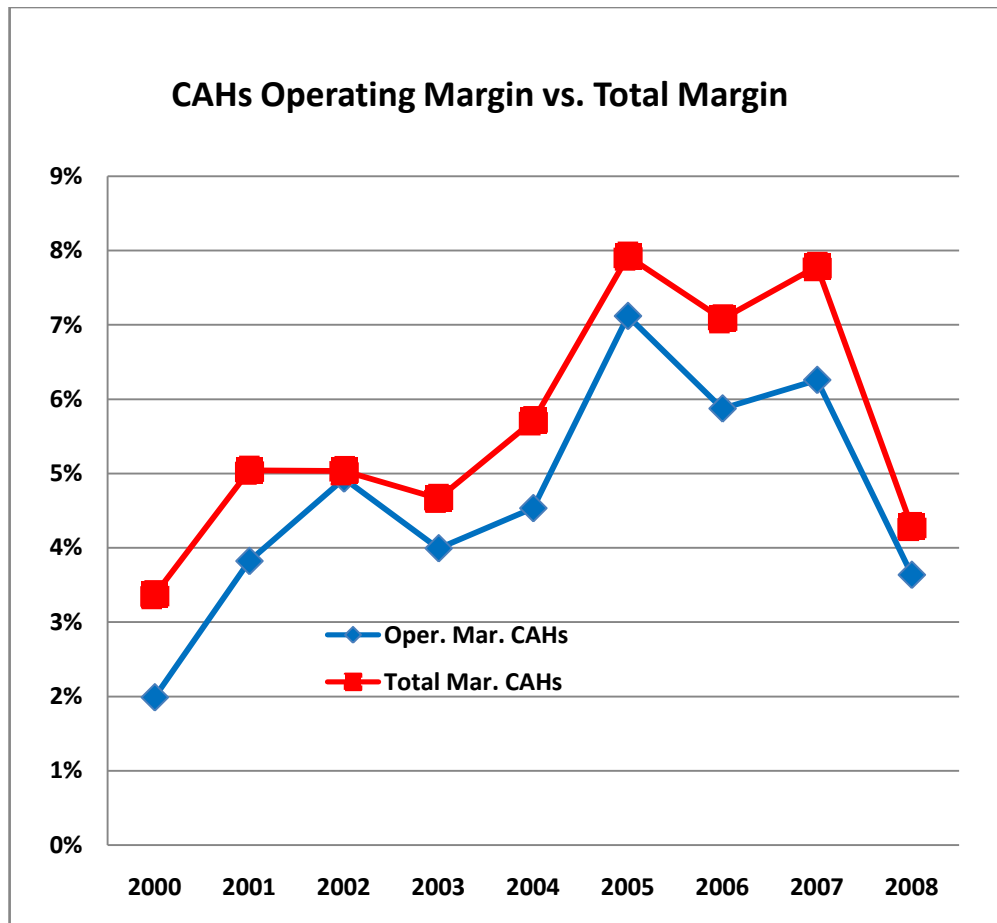
OPERATING MARGIN RATIO

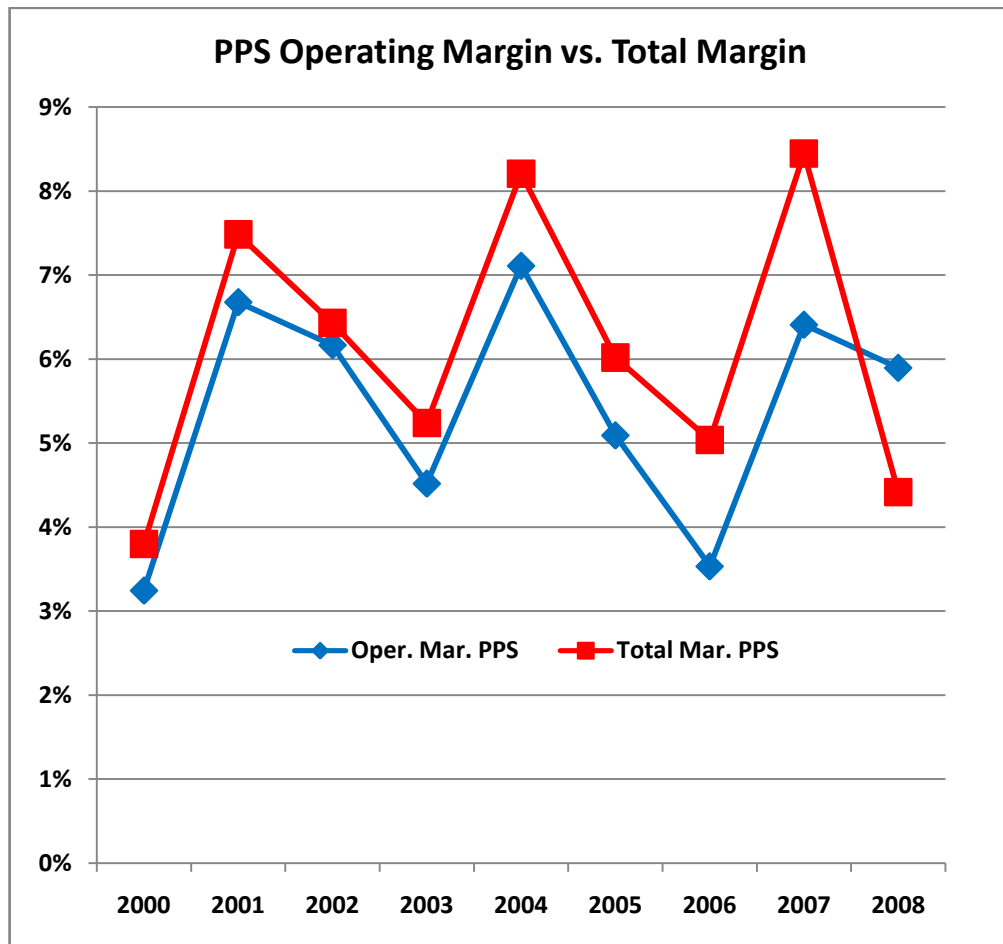
The Operating Margin ratio measures the percent of operating income to total operating revenue. It is used by many analysts as a primary measure of operating profitability. The Operating Margin ratio does not reflect investment income or losses. The following graphs indicate that CAHs had a lower Operating Margin in 2008 than either PPS or All Wisconsin.



As previously discussed, Total Margins for all groups in 2008 were approximately the same (4%). The ratio analysis indicates that while Total Margins are about the same, Operating Margins for

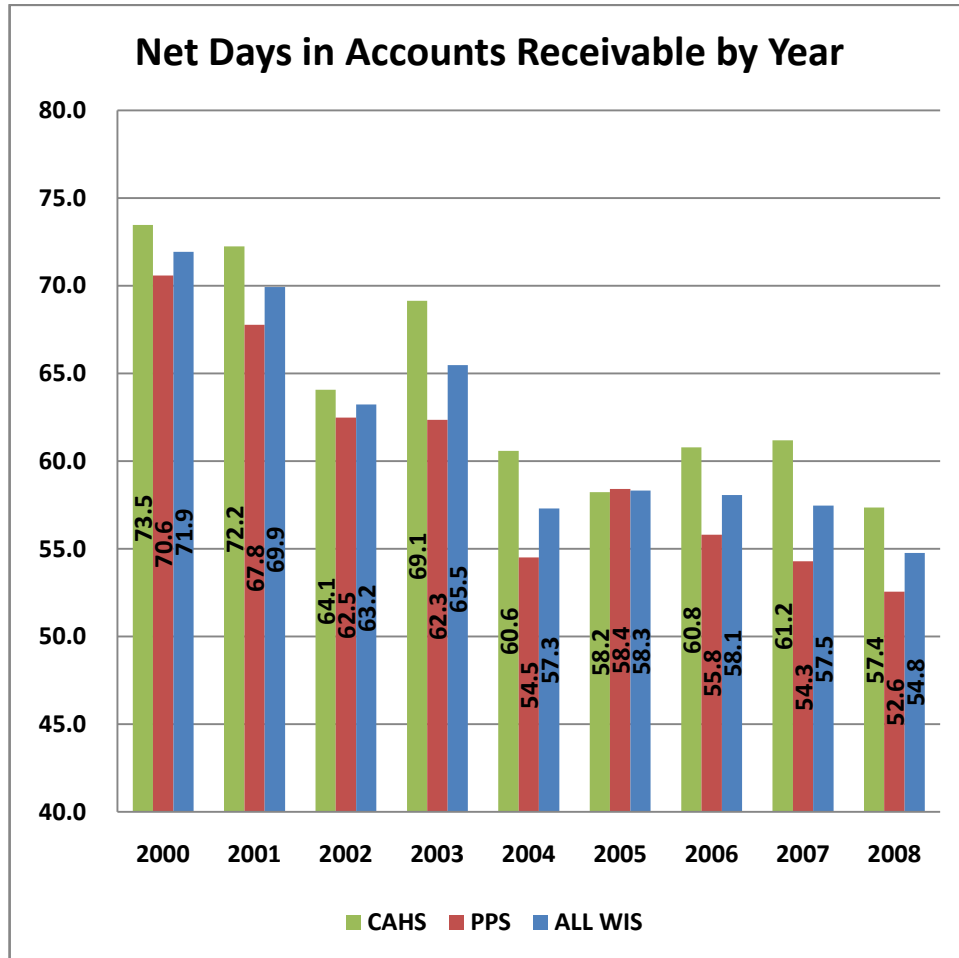
the PPS group was higher in 2008 than CAHs (see graphs below). Because of the significant losses in 2008 in the stock and bond markets, it appears the PPS group experienced higher investment losses than CAHs.

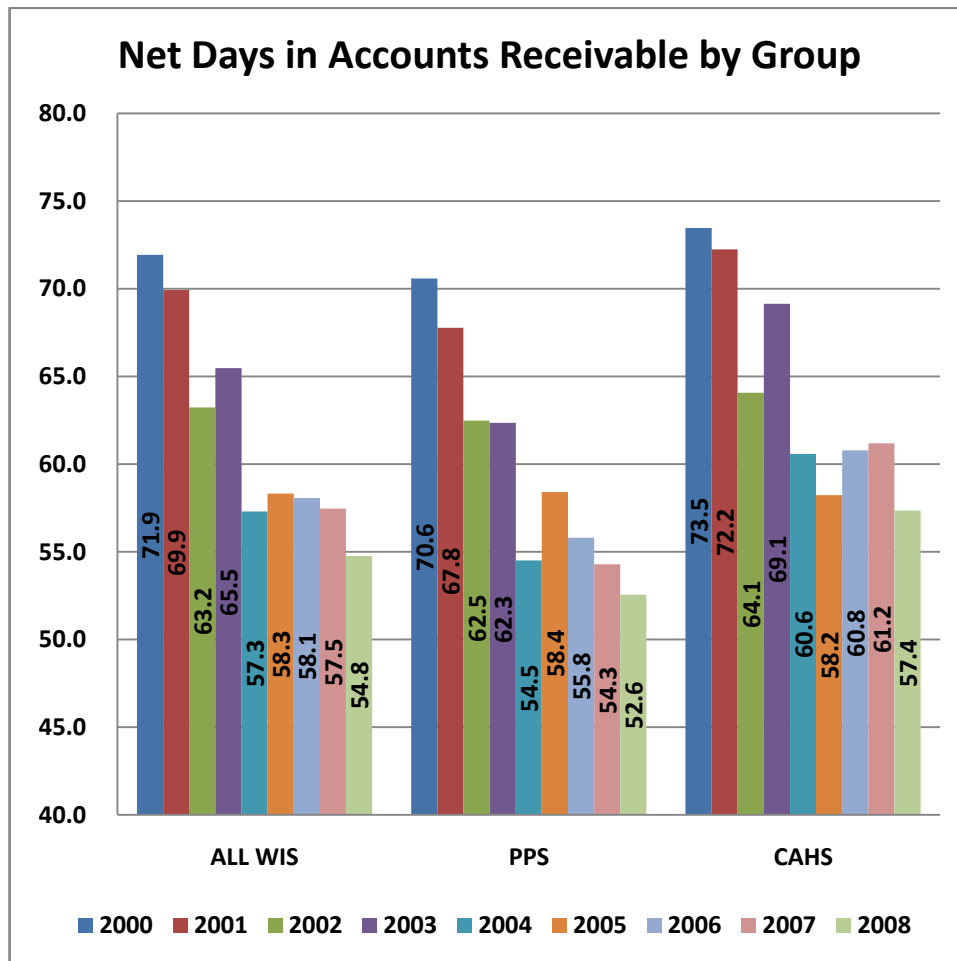




NET DAYS IN ACCOUNTS RECEIVABLE

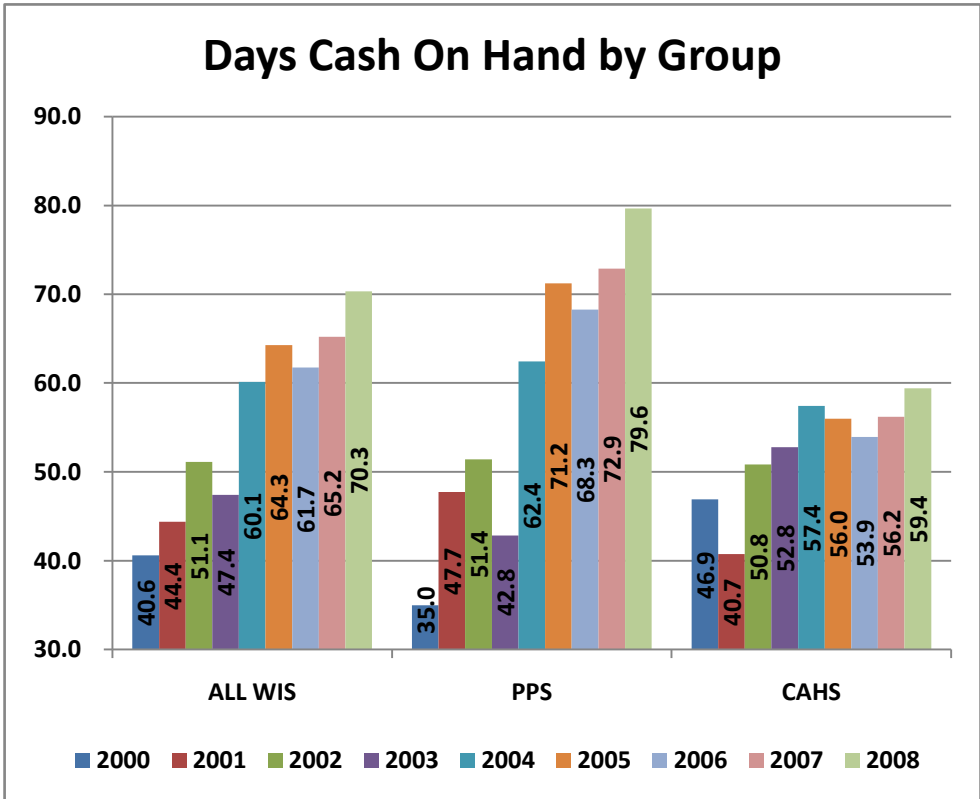
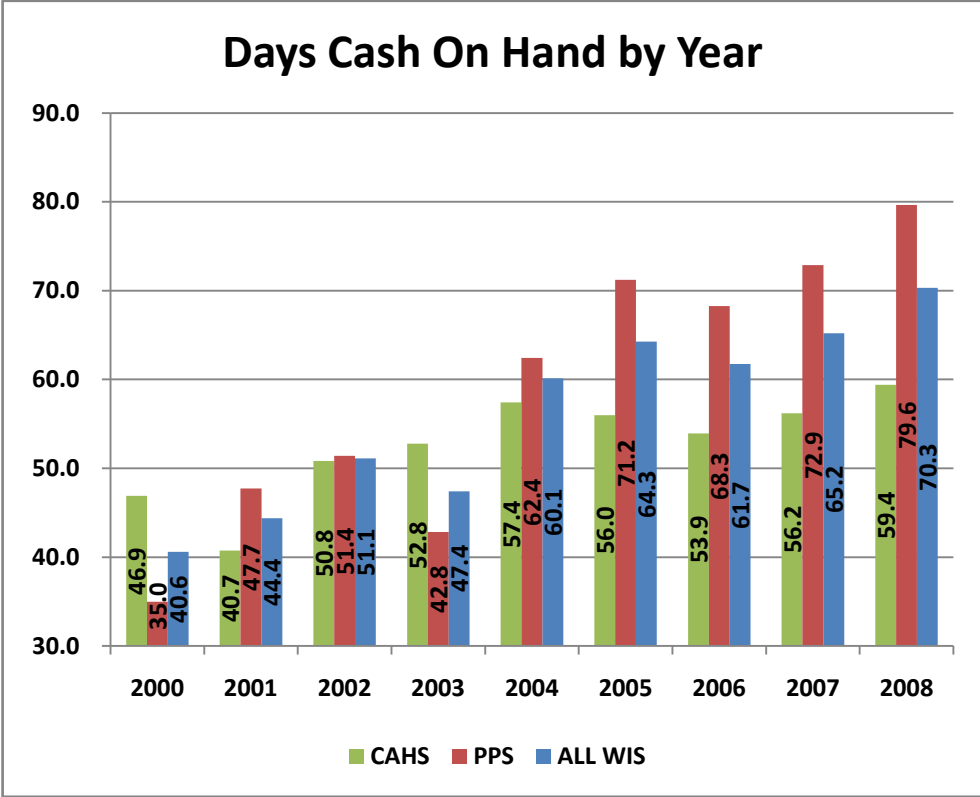
Net Days in Accounts Receivable is a ratio that indicates how quickly services are billed and paid. Generally, low numbers for this ratio are favorable. Decreasing trends show improvement in the collection process. Lower Net Days in Accounts Receivable usually translates into higher cash account balances. All groups have shown a general improvement in collecting accounts receivable since 2000. CAH's Net Days increased in 2006 and 2007 but decreased in 2008. CAHs continue to experience higher Net Days in Accounts Receivable than PPS and All Wisconsin. One reason may be more self-pay patients which typically take longer to collect.





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 slight increase for all three groups in 2008. As mentioned previously, Days in Accounts Receivable have decreased since 2000. Decreasing Days in Accounts Receivable has a positive impact on Days Cash on Hand.



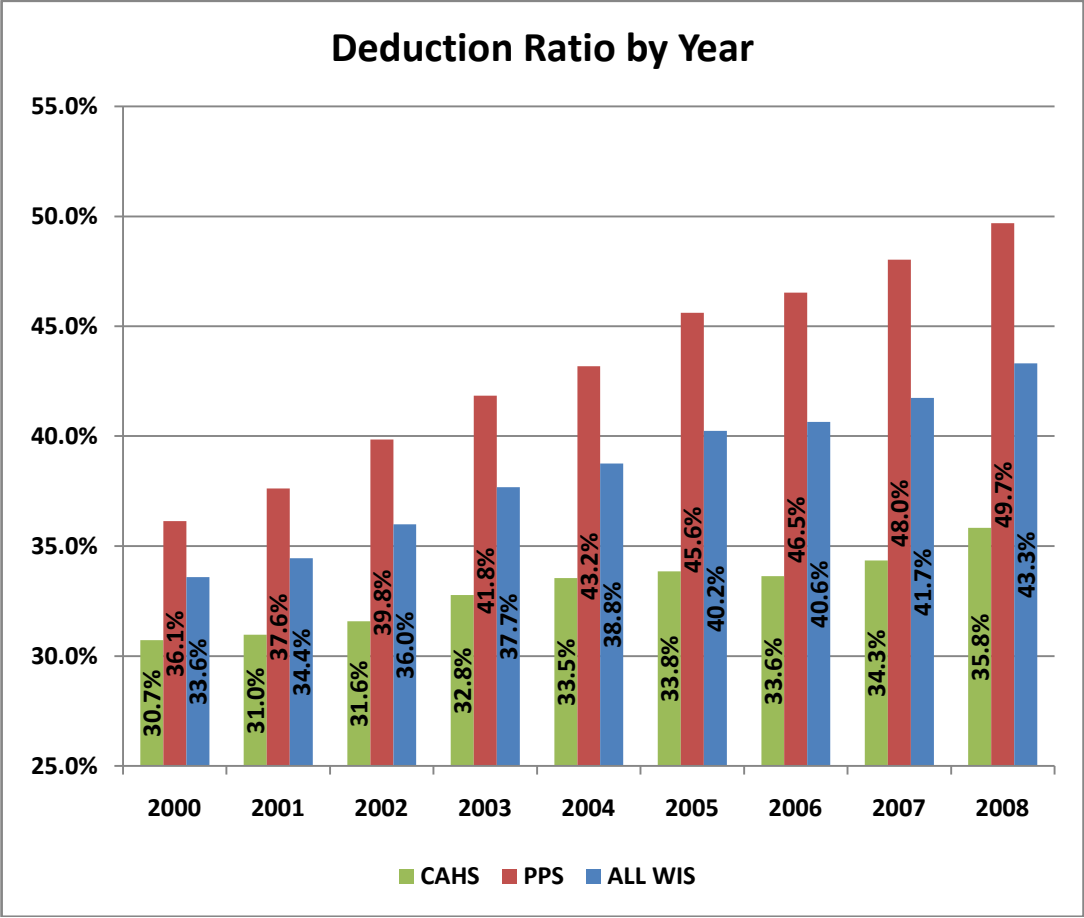
DEDUCTION RATIO

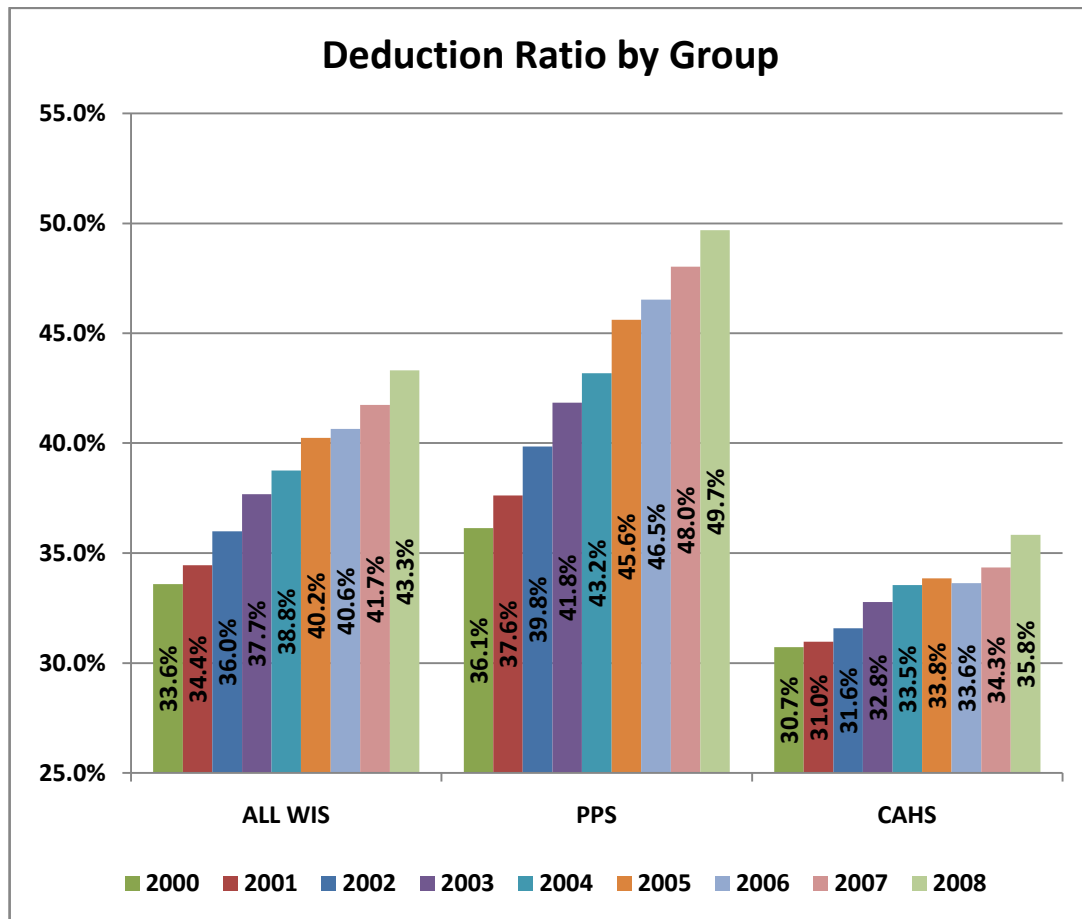
The deduction ratio shows the percent difference between hospital charges and actual cash paid for services provided. The deductions include government payers such as traditional Medicare and Medicaid, Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Medicare Advantage plans, Medicaid HMO plans, and private pay discounts including charity care. Bad debts are considered expenses and are not included in the deduction ratio. 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 changes. 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 payments contributes to the rise in the deductible ratio.

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

	WI	CMS IPPS
	Average Price Increase	% Chg in Payments Per Case
Year		
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%

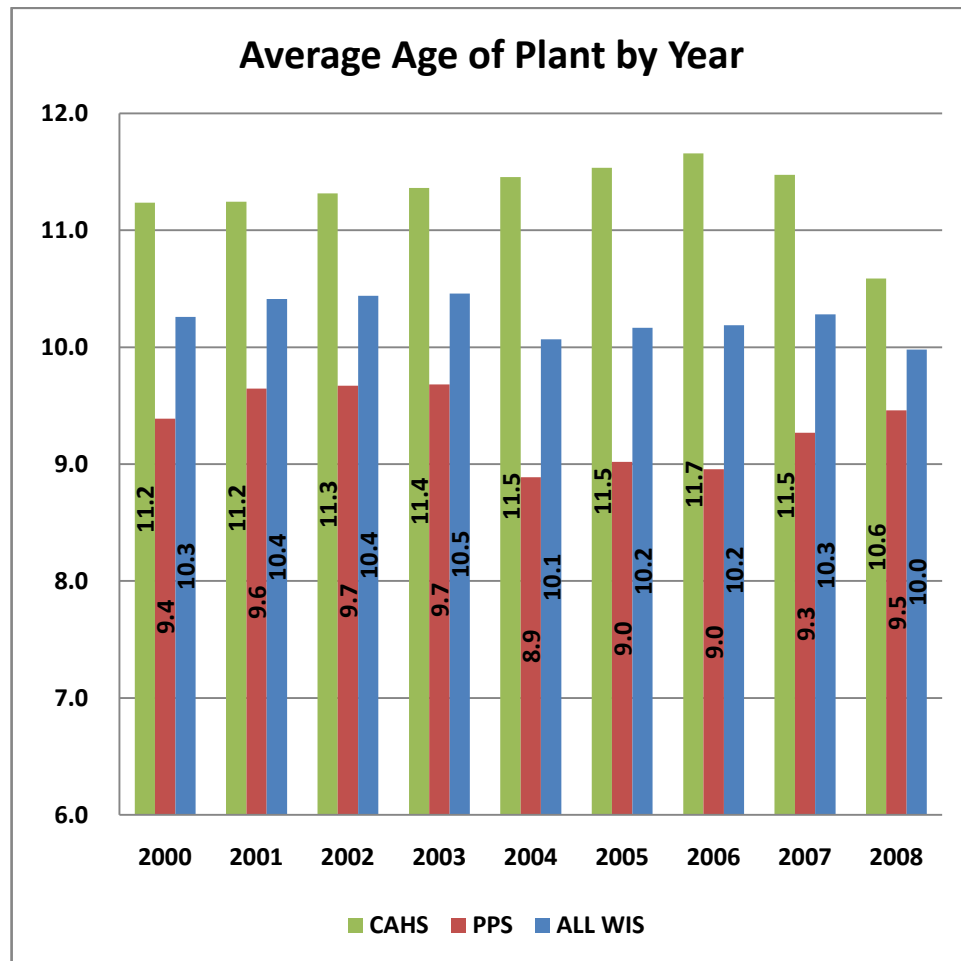
The following graphs indicate a steady increase in the deduction ratio for all groups from 2000 through 2008. It also shows a much higher ratio for PPS and All Wisconsin than for CAHs. Payer mix, managed care penetration, and charge structure are three reasons the deduction ratio may be higher for some facilities.

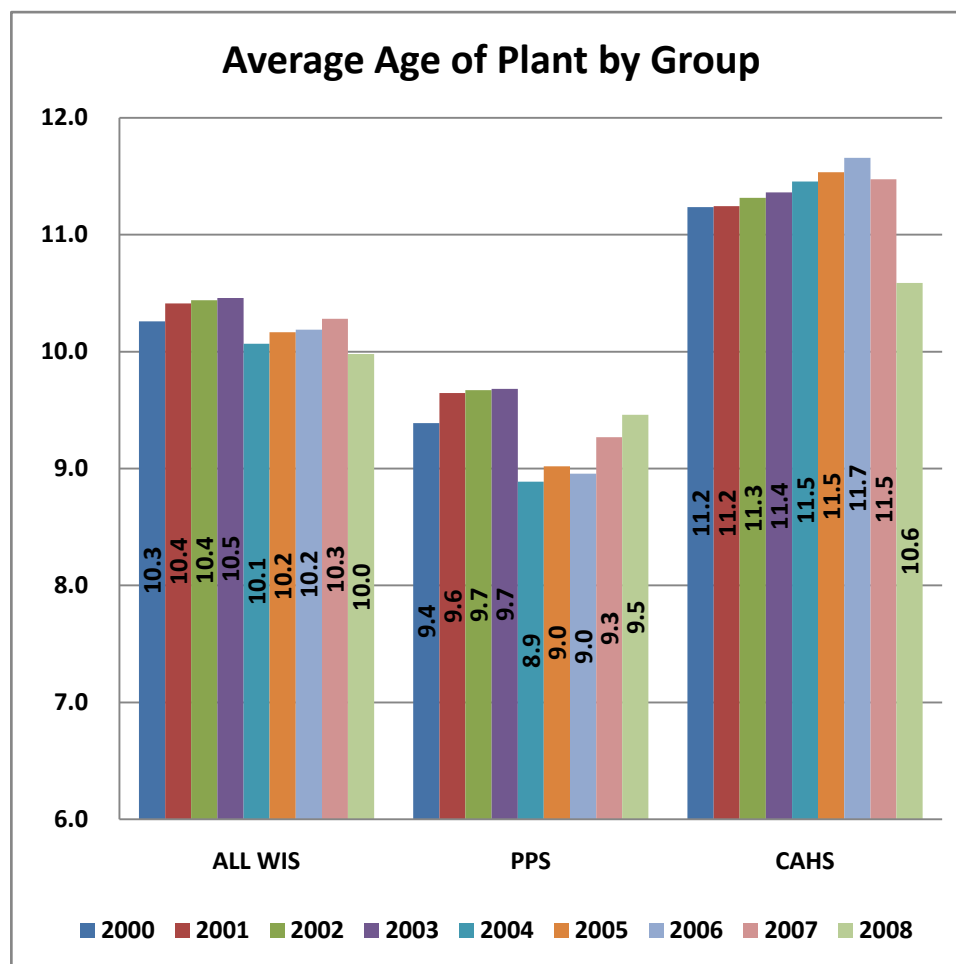




AVERAGE AGE OF PLANT

As discussed in the previous studies, rural hospitals generally have struggled 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 many feel that it should be closer to 7.5. Average Age of Plant is calculated by dividing Accumulated Depreciation by Depreciation Expense. Lower ratios are favorable as are decreasing trends. The following graphs show a significant decrease in Average Age of Plant for the All Wisconsin group for 2008 to 10.0. The graphs indicate that CAH's Average Age of Plant is still higher than the PPS group but the gap narrowed in 2008. This would indicate that CAH status is helping rural hospitals modernize plants and invest in capital improvements.

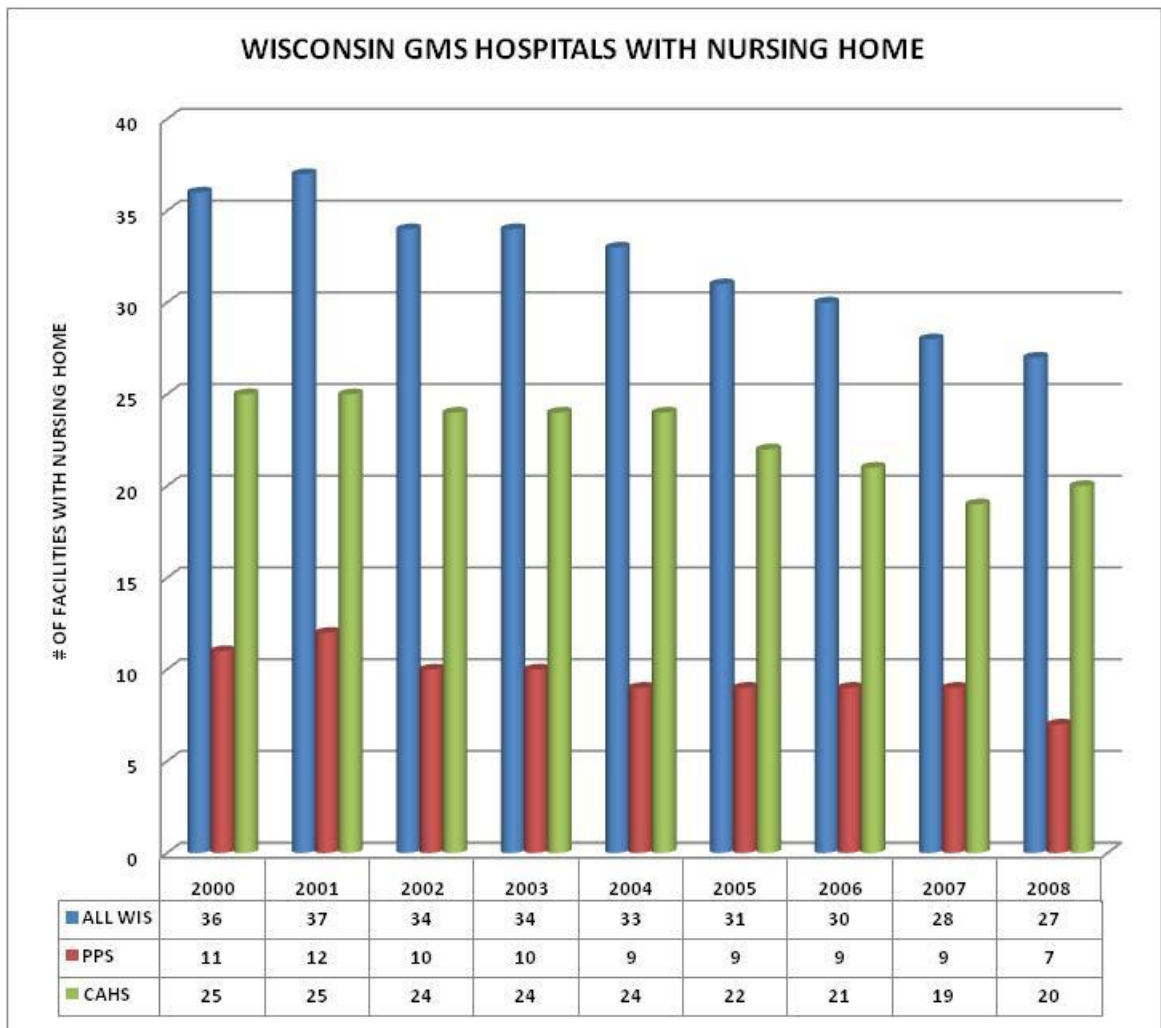




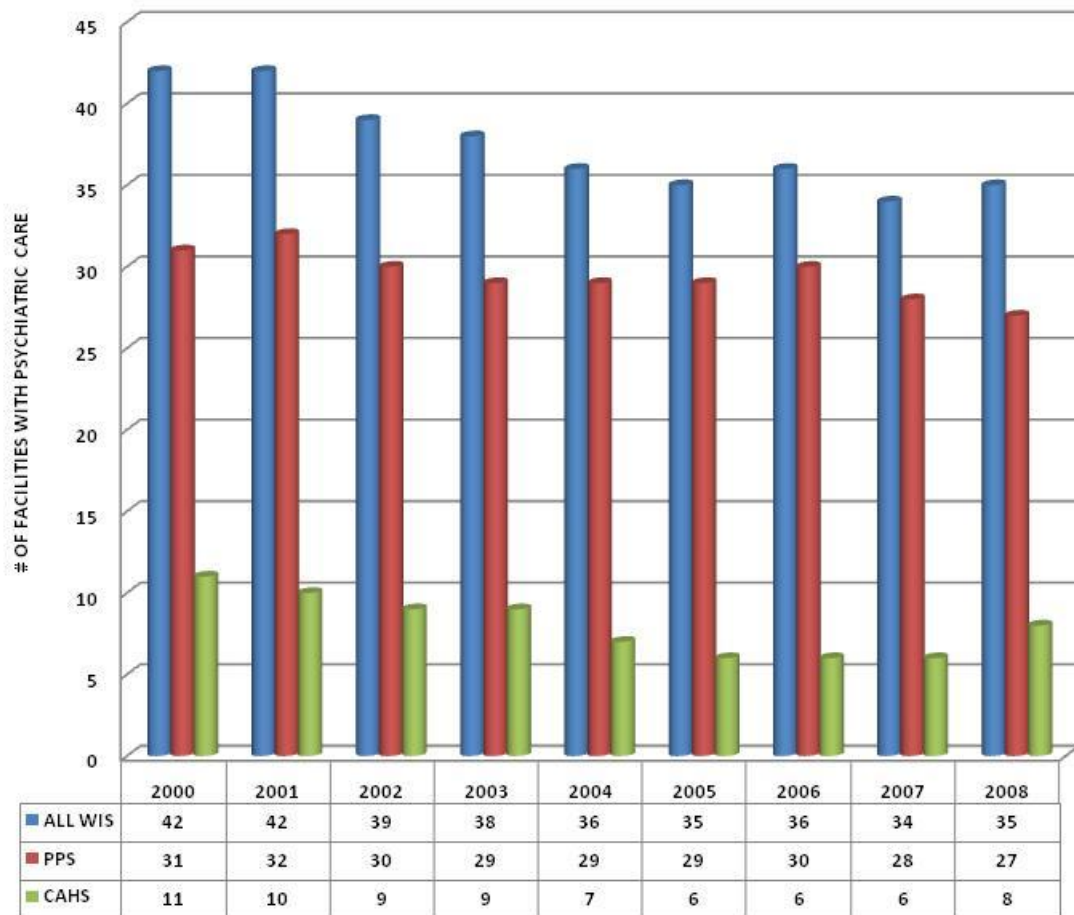
CHANGES IN SERVICES

Since this study covers nine years (2000 through 2008), enough time has passed to accurately assess the changes in CAH services. As mentioned, CAHs are reimbursed 101% of the cost they incur for covered hospital 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. Therefore, under a CAH Medicare cost report, both direct and indirect cost are allocated to the Skilled Nursing Facilities (SNF) and excluded from hospital costs. 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 under the hospital PPS. The following graphs show services provided by “All Wisconsin”, “PPS”, and “CAH” groups. The information was taken from the Annual Survey of Hospitals submitted to the WHA Information Center. Only

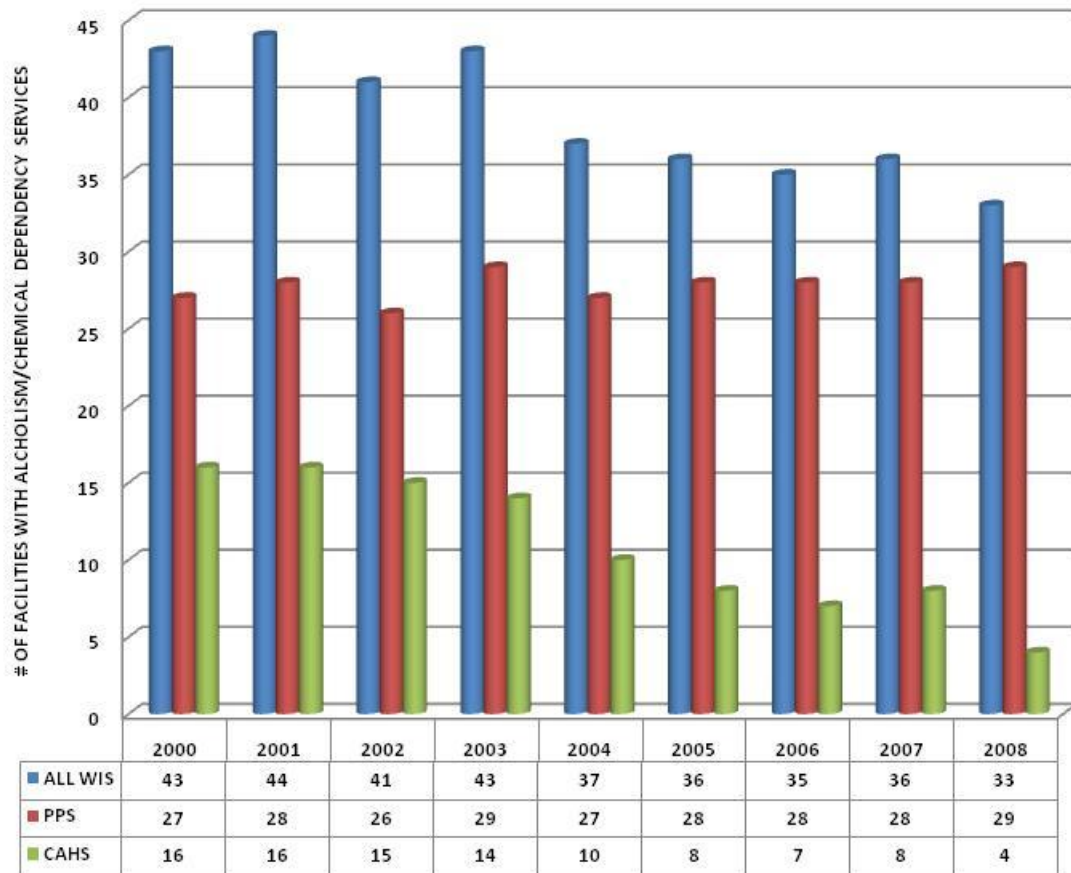
General Medical/Surgical (GMS) hospitals are included. The service must be provided in the hospital but not necessarily in a distinct and separate unit.



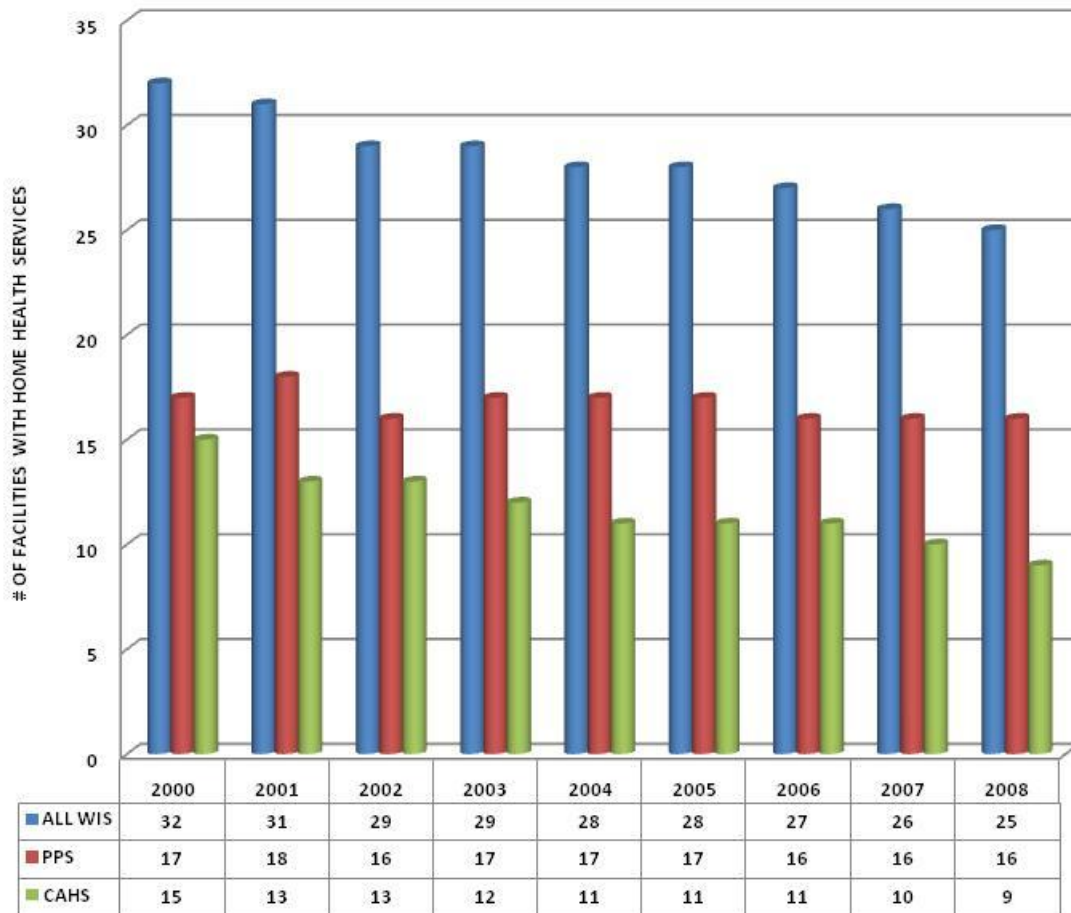
WISCONSIN GMS HOSPITALS WITH PSYCHIATRIC CARE

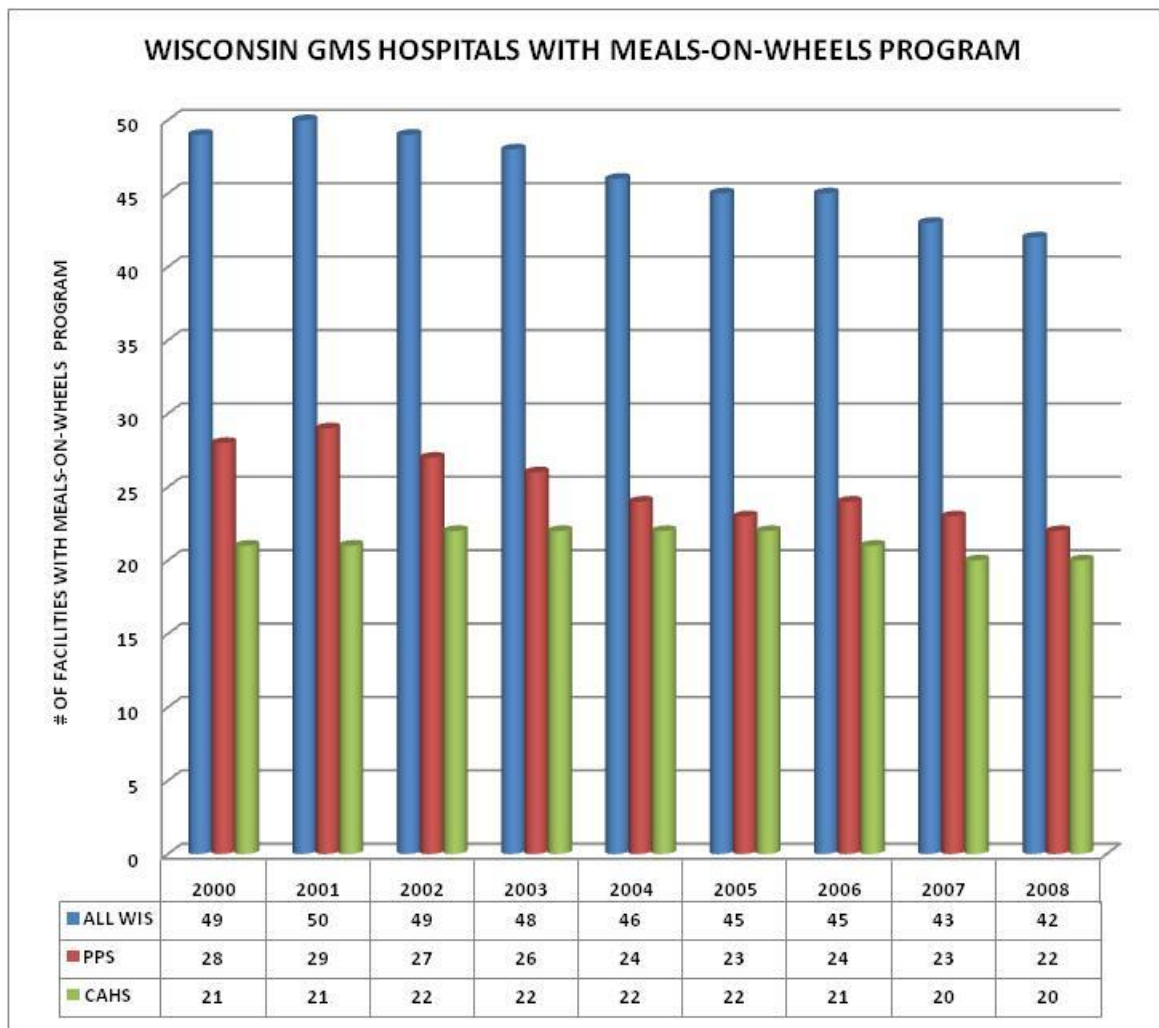


WISCONSIN GMS HOSPITALS WITH ALCOHOLISM/CHEMICAL DEPENDENCY SERVICES



WISCONSIN HOSPITALS WITH HOME HEALTH SERVICES

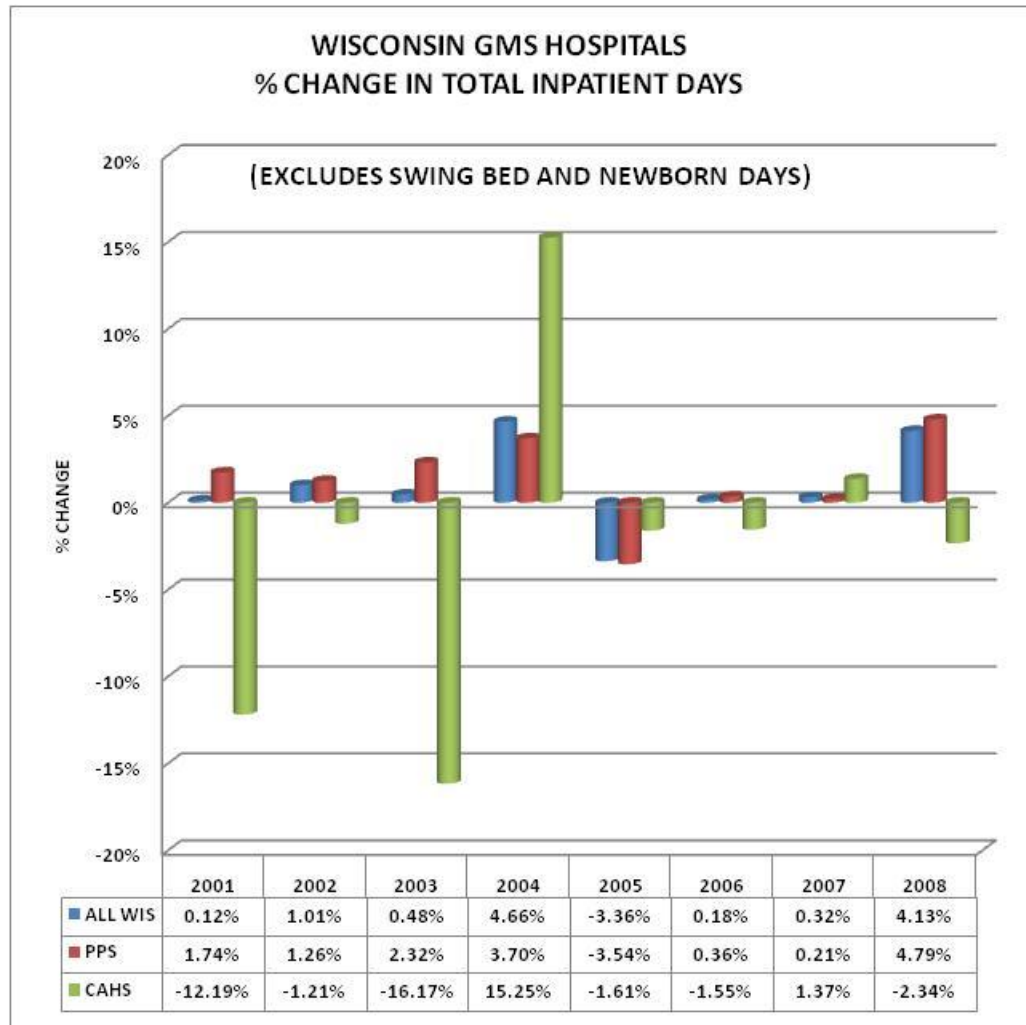




CAHs may determine that the allocation of cost to a non-reimbursable, a low-Medicare utilization area, or a service covered under another Medicare payment methodology has a negative impact on overall financial performance. Fixed costs such as depreciation and interest will likely be incurred if the service is provided or not. Hospitals decide what services to provide based on a number of factors such as community need, make-up of the medical staff, or to gain advantage over competitors. Each individual facility must determine which services contribute to the health of their communities as well as their own financial health. The impact on Medicare payments can be a factor for CAHs in deciding which services to provide.

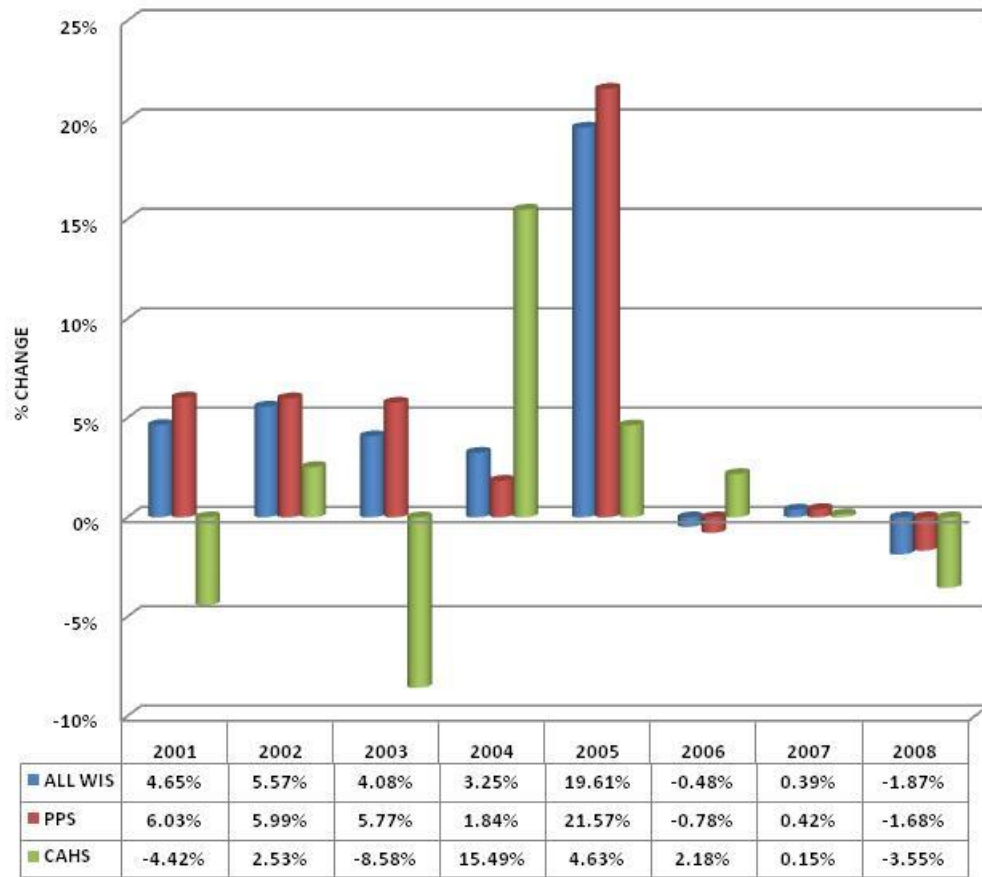
UTILIZATION

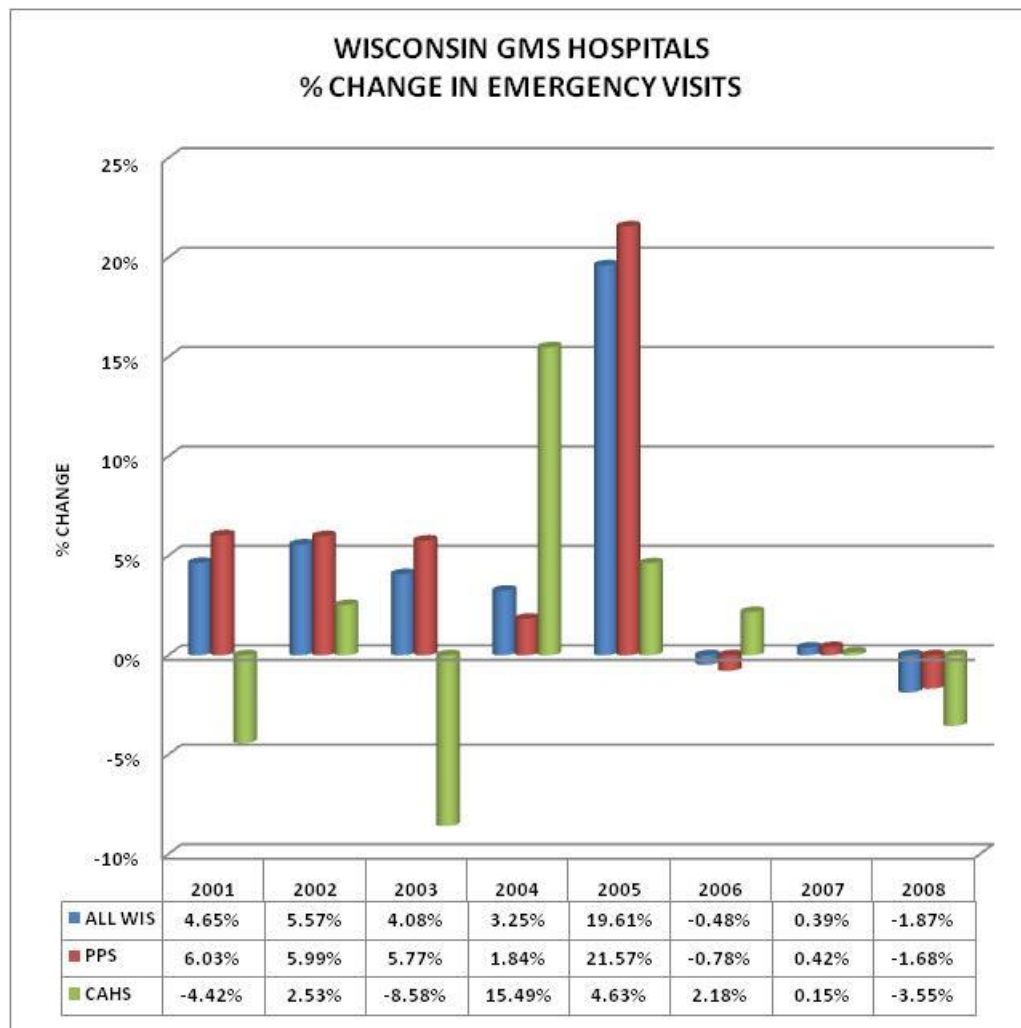
The following graphs show the percentage change from the previous year for several key services. CAH's inpatient days decreased in 2008 from 2007 while PPS and All Wisconsin days increased.



The number of surgical operations and emergency visits also declined more rapidly in 2008 from 2007 for CAHs than the PPS group.

**WISCONSIN GMS HOSPITALS
% CHANGE IN SURGICAL OPERATIONS**





CAPITAL FINANCING NEEDS

One of the most pressing needs of CAHs is access to capital. Many rural hospitals are due for major renovation or replacement because they are over 50 years old. However, lenders may still consider CAHs to be high-risk due to past financial performance. As reported in previous studies, the Average Age of Plant has begun to improve. However, capital needs continue to be near the top of list of priorities for rural hospitals. Based on a February 2009 survey, the total estimated nationwide capital needs of CAHs certified as of December 2005 is \$4.5 billion.² Of the 381 CAHs included in this national telephone survey, over 80% of the CAHs that had pursued a capital loan during the two years preceding the survey were successful. CAHs reported capital needs for investment in health information technology has doubled since 2004. The study indicated about 10% of the facilities, however, because of existing debt or the inability to meet other criteria, could not pursue capital for basic needs such as fire suppression systems. Also, as mentioned in

² Walter Gregg, MA, MPH, University of Minnesota Rural Health Research Center, The Capital Investment Needs of Critical Access Hospitals (CAHs): Results of the 2007 National CAH Survey, 2.

the “Future of Critical Access Hospitals” section, a recent American Hospital Association (AHA) study states 80% of hospitals have stopped, postponed or scaled back projects planned or already in progress in response to the pressures of the economic downturn. Credit rating agency Standard & Poor’s doubled the number of downgrades in 2008. The agency indicated that declining operating margins no longer can be offset by strong non-operating revenues.

MEDICARE RECOVERY AUDIT CONTRACTOR (RAC)

A looming potential financial problem for all hospitals, including CAHs, is the Medicare Recovery Audit Contractor (RAC) program. This program was established as a demonstration program to identify improper Medicare payments by the Medicare Modernization Act of 2003. RACs were paid on a contingency fee basis, receiving a percentage of the improper overpayments and underpayments they collect from providers. Under the demonstration program that operated from March 2005 to March 2008 in California, Florida and New York, South Carolina and Massachusetts, RACs could review the last four years of provider claims for the following types of services: hospital inpatient and outpatient, skilled nursing facility, physician, ambulance and laboratory, as well as durable medical equipment. The RACs used proprietary software programs to identify potential payment errors in such areas as duplicate payments, fiscal intermediaries’ mistakes, medical necessity and coding. RACs also conducted medical record reviews. In July 2008, CMS reported that the RACs had succeeded in correcting more than \$1.03 billion in Medicare improper payments. Approximately 96 percent (\$992.7 million) of the improper payments were overpayments collected from providers, while the remaining 4 percent (\$37.8 million) were underpayments repaid to providers. The Tax Relief and Health Care Act of 2006 made the RAC program permanent and authorized the CMS to expand the program to all 50 states by 2010. Nationwide rollout of the permanent RAC program is underway, with all states scheduled to come on board this year.

QUALITY MEASUREMENTS

As more consumers become educated about healthcare services, quality of care information is becoming widely available. Quality improvement (QI) and measurement remains high on the list of the hospital industry concerns. Currently, quality issues appear prominently in the proposed healthcare bill along with controlling costs and coverage issues. 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. CMS makes quality data available through its Hospital Compare website. Patient abstracts from 2005, 2006, and 2007 provide data for evaluation. The 2007 measure set included 24 care measures that reflect recommended treatments for acute myocardial infarction (AMI), heart failure, pneumonia and surgical infection prevention. Because of low volumes, CAH data is combined. Based on 2007 discharges, Wisconsin CAH patients receiving recommended care for most measures meet or exceed the CAH national average. Wisconsin CAH participation in Hospital Compare has also been higher than the national average and has increased from 75.4% in 2005 to 84.5% in 2006 to 91.5% in 2007.³

³ Michelle Casey, MS, Michele Burlew, MS, Ira Moscovice, PhD, University of Minnesota Rural Health Research Center, Episystems, Inc., under contract with the University of Minnesota, CAH Participation and Quality Measure Results for Hospital Compare 2007 Discharges and 2005-2007 Trends: National and Wisconsin Results, 2.

Also, Wisconsin's CAHs participate in the WHA's CheckPoint program, which makes quality data available to the public through a website.

HEALTH INFORMATION TECHNOLOGY

The Rural Wisconsin Health Cooperative (RWHC), a group of 35 small, rural hospitals in Wisconsin, in partnership with the Wisconsin Office of Rural Health, was awarded \$1.6 million grant to build a shared hospital information system for rural Wisconsin hospitals. The grant was awarded by the Federal Health Resources and Services Administration as part of their CAH HIT Network program. The RWHC Information Technology Network (RWHC ITN) will service hospitals and physicians by providing unified, integrated electronic information to support healthcare systems to reduce avoidable medication errors and robust and affordable EHR applications. The Wisconsin eHealth Care Quality and Patient Safety Board was created on November 2, 2005. Its purpose is to develop a strategic action plan for the statewide adoption and exchange of electronic health records in five years. Consistent with Wisconsin eHealth Initiative goals, RWHC ITN will accelerate EHR adoption in small and rural Wisconsin hospitals. Following an initial implementation period of the grant, the organization intends to work with larger hospitals toward regional data exchange that will further enhance patient safety and system efficiency for Wisconsin residents and healthcare providers.

Many CAHs have administrative and financial health information technology (HIT) systems such as billing, accounting, and patient registration. However, due to the high costs, most CAHs have not made major investments in clinical applications such as electronic medical records (EHR). With cost-based Medicare reimbursement and additional grants, this may be changing. Louis Wenzlow, Director of Health Information Technology for the Rural Wisconsin Health Cooperative, recently prepared a study for the Wisconsin Office of Rural Health. The February 24, 2009, study "Density of HIT Adoption in Wisconsin Rural Hospitals" was conducted to determine the level of HIT system adoption in rural Wisconsin hospitals and help rural hospital benchmark their progress in this area to their peers. Here are some of the conclusions from the study:

- HIT adoption of identified systems has increased from 50% in 2006 to 61% in 2008. In addition, study participants plan on 2008-2009 implementations.
- Only 23% of rural hospitals had "high" rates of system adoption compared to 40% of all Wisconsin hospitals.
- Smaller rural hospitals have the lowest HIT adoption rates.
- Although several grant programs are available, HIT costs are prohibitive for many rural hospitals.
- Nearly 80% of rural hospitals primarily use one vendor for HIT needs.

Fewer than 50% of the study participants had advance clinical 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. The recently enacted American Recovery and Reinvestment Act of 2009 (ARRA) may help provide hospitals the funding and incentives to implement these systems. For more information on ARRA, see the "Recent Legislation" section of this study.

RECENT LEGISLATION

In July 2008, MIPPA was approved by Congress and became law. Below is a summary of key provisions of the law:

Medicare Advantage Improvements

- Reduced overpayments to private Medicare Advantage plans by phasing out an adjustment for indirect medical education (IME).
- Requires private fee-for-service (PFFS) plans to establish provider networks and to measure and report on the quality of care they deliver.
- Reduces money in the Medicare Advantage Stabilization Fund.
- Prohibits and limits certain sales and marketing activities under Medicare Advantage and Part D prescription drug plans.

Beneficiary Improvements

- Provides Medicare mental health parity.
- Offers new preventive benefits to Medicare beneficiaries.
- Extends the exceptions process for therapy caps.
- Modifies the Medigap program.
- Provides better care for patients with kidney disease, also known as end-stage renal disease (ESRD).
- Delays a competitive bidding demonstration for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS).

Low-Income Improvements

- Extends the Qualifying Individual (QI) program.
- Raises allowed asset levels in the Medicare Savings Program.
- Codifies suspension of the late enrollment penalty for Part D beneficiaries who qualify for Low Income Subsidy (LIS) assistance.
- Excludes the value of life insurance policies and in-kind support from resource calculations for LIS.

Part D Benefit Improvements

- Requires Part D plans to cover benzodiazepines and barbiturates.
- Codifies a requirement for Part D plans to cover most drugs in certain important classes of drugs.

Physician Services under Part B

- Blocks a scheduled 10.6 percent cut to physician fees.
- Incentivizes adoption of electronic prescribing by physicians.
- Increases incentives for physician quality reporting.

The Children's Health Insurance Reauthorization Act of 2009 was signed into law on February 4, 2009. The law both extends and expands the State Children's Health Insurance Program (SCHIP), which was due to expire on March 31st, 2009. The act provides \$32.8 billion over the next four and a half years to both maintain existing coverage for around 7 million children and to expand coverage to an estimated 4.1 million additional children. The program will be financed through increases in federal tobacco taxes, including a 62-cent-per-pack increase in the cigarette excise tax.

On February 17, 2009, President Obama signed in law ARRA. This package is intended to provide a stimulus to the weakened economy. The \$787 billion bill includes tax relief, expansion of unemployment benefits, and other social welfare provisions, and domestic spending on education, health care, and infrastructure, including the energy sector. The Act also requires a study of the effectiveness of medical treatments. More than \$147 billion is allocated for health-related expenditures. The bill allocates the funding as follows:

- \$86.6 billion for Medicaid
- \$24.7 billion to provide a 65 percent subsidy of health care insurance premiums for the unemployed under the Consolidated Omnibus Budget Reconciliation Act (COBRA) program
- \$19 billion for health information technology
- \$10 billion for health research and construction of National Institutes of Health facilities
- \$1.3 billion for medical care for service members and their families (military)
- \$1 billion for prevention and wellness
- \$1 billion for the Veterans Health Administration
- \$2 billion for Community Health Centers
- \$1.1 billion to research the effectiveness of certain healthcare treatments
- \$500 million to train healthcare personnel
- \$500 million for healthcare services on Native American reservations
- \$19 billion to accelerate the adoption of HIT systems
- Strengthened federal privacy and security provisions to protect personally-identifiable health information
- Approximately \$87 billion in additional federal matching funds over two years to help states maintain their Medicaid programs in the face of state budget shortfalls
- \$1.1 billion to support comparative effectiveness research
- \$1 billion for a new Prevention and Wellness Fund
- Provisions to help unemployed workers maintain health insurance coverage under the COBRA law
- A provision blocking a fiscal year 2009 reduction in Medicare payments to teaching hospitals related to capital payments for indirect medical education
- A provision blocking a fiscal year 2009 Medicare payment cut to hospice providers related to a wage index payment add-on
- Technical corrections to the Medicare, Medicaid, and SCHIP Extension Act of 2007 related to Medicare payments for long-term care hospitals
- A temporary increase in states' annual disproportionate share hospital allotments
- An extension of moratoria on Medicaid regulations for targeted case management, provider taxes, and school-based administration and transportation services through June 30, 2009, and a new moratorium on a Medicaid regulation related to hospital outpatient services through June 30, 2009
- An extension of Transitional Medical Assistance and the Qualified Individual program
- Medicaid prompt payment requirements for nursing facilities and hospitals

The IT provisions in ARRA provide incentives and support for the adoption of certified EHRs. The Act authorizes bonus payments for eligible professionals and hospitals participating in Medicare or Medicaid if they become “meaningful users” of certified EHRs. These bonus payments will help lessen the financial burden for many healthcare providers to adopt this technology. The incentive bonuses will begin in 2011. Beginning in 2015, the Act mandates

penalties under Medicare for eligible professionals and hospitals that fail to demonstrate meaningful use of certified EHRs. CMS is overseeing and administering the incentive program and is coordinating with the Office of the National Coordinator for Health Information Technology (ONC). ONC is leading the effort to establish an initial set of Health IT and EHR standards, implementation specifications and certification criteria. These items will explain how to meet the incentive requirements of certified EHR and meaningful use. CMS is contributing to this effort. Under ARRA:

- Incentive payments are provided, beginning with October 2010, for eligible hospitals and CAHs that are meaningful EHR users. Reduced payment updates beginning in FY 2015 will apply to eligible hospitals that are not meaningful EHR users.
- An eligible hospital that is a meaningful EHR user could receive up to four years of financial incentives payments, beginning with fiscal year 2011. There will be no payments to hospitals that become meaningful EHR users after 2015.
- The incentive payment for each eligible hospital would be calculated based on the product of an initial amount, the Medicare share, and a transition factor.
- For CAHs that are meaningful EHR users, reasonable costs for the purchase of certified EHR technology would be computed by expensing such costs in a single payment year, rather than depreciating them over time. In addition, incentive payments for CAHs would be based on the Medicare share formula plus 20 percentage points (not to exceed a total of 100 percent). CAHs would receive a prompt interim payment for the Medicare share of such costs (subject to reconciliation). Payments would not be made with respect to a cost reporting period beginning during a payment year after 2015, and in no case would a CAH receive payment with respect to more than 4 consecutive payment years.
- Hospitals that are not meaningful users for a fiscal year would receive a net reduction of $\frac{1}{4}$, $\frac{1}{2}$, and $\frac{3}{4}$ of the market basket update that would apply in 2015, 2016, 2017 and thereafter, respectively. The Secretary of HHS may, on a case-by-case basis, exempt a hospital if requiring the hospital to be a meaningful EHR user would result in a significant hardship. Eligible CAHs that are not meaningful EHR users for a fiscal year and otherwise would be paid at 101 percent of reasonable costs are subject to the following payment adjustments: in FY2015, reimbursement for inpatient services at 100.66 percent of reasonable costs; in FY2016, reimbursement for inpatient services at 100.33 percent of reasonable costs; and in FY2017 and each subsequent year, 100 percent of reasonable costs.

Also, at the time of this study, major healthcare reform is being debated in Congress. The reform currently under consideration is called “America’s Affordable Health Choices Act” (AAHCA). Although many details are yet to be determined, some of the major areas the bill addresses are:

- Coverage
- Affordability
- Prevention and wellness
- Workforce issues
- Costs

Medicare Advantage

Medicare Advantage plans have brought significant change to the Medicare program. A major challenge to the gains CAHs have experienced under traditional Medicare is the growth of private Medicare Advantage plans (see Table 8).

Table 8: Government Program Utilization Based on Revenue

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

As this graph indicates, traditional Medicare revenue as a percent of total revenue has declined because of the increased beneficiary participation in the private Medicare Advantage plans. The decrease in total government payer utilization (traditional Medicare and Medicaid) has been offset partly due to the increase in Medicaid utilization. The impact of healthcare reform currently being debated by Congress on the Medicare Advantage plan participation is unclear. It is clear, however, that gains in reimbursement CAHs receive from traditional Medicare may be in jeopardy from continued growth in the Medicare Advantage plans. The Medicare Advantage program creates opportunities for increased access and services to Medicare beneficiaries, but private plan growth may create major reimbursement problems for CAH providers. A July 2009 CMS report on Medicare Advantage penetration (see Table 9 below) indicates that over 26% of Wisconsin Medicare beneficiaries are now members of a private plan.

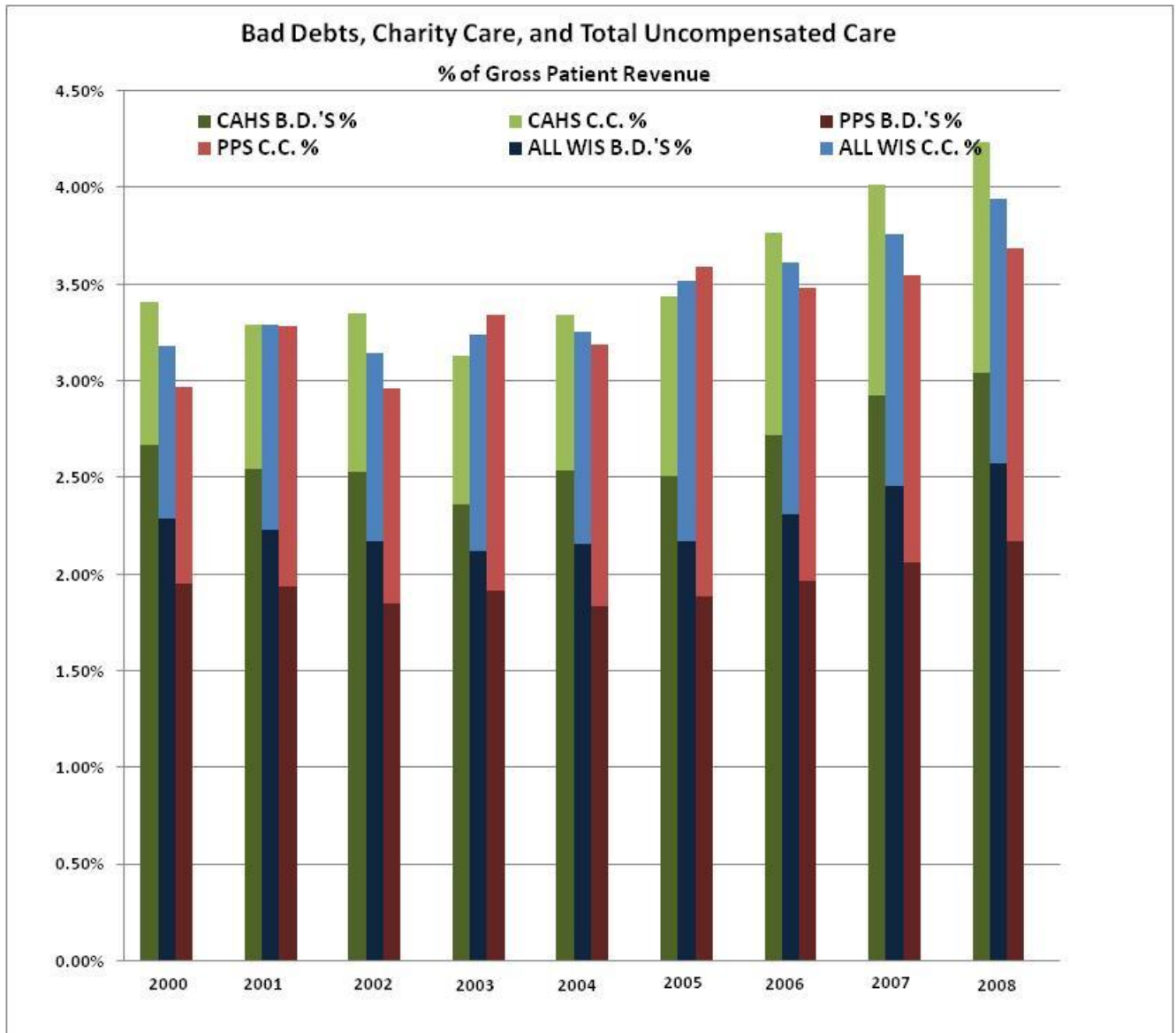
Table 9: Wisconsin vs. National Medicare Advantage Plan Penetration

MEDICARE ADVANTAGE PLAN PENETRATION*										
	YEAR									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
U.S.	16.8%	15.0%	13.2%	12.2%	12.1%	12.7%	16.3%	19.0%	21.0%	22.5%
Wisconsin	5.1%	5.0%	2.6%	3.1%	4.7%	7.0%	15.0%	20.4%	23.3%	26.1%
*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 Medicare payment, some Medicare Advantage plans struggle to pay providers correctly. Delays in payments due to new billing and reporting requirements are also common. As Medicare Advantage plans continue to grow, CAHs payment gains under traditional Medicare are at risk.

UNCOMPENSATED CARE

Uncompensated Care costs have been and continue to be an issue for all healthcare providers. Uncompensated Care is defined as the total of Bad Debts and Charity Care. Although the definition of two categories may vary slightly from one facility to another, the basic concept is a Bad Debt occurs when a patient is determined to have sufficient assets to pay the obligation but decides not to. Charity Care patients typically are without resources to pay the bill. The following graph is a stacked bar graph which shows Bad Debts and Charity Care % of Total Revenue for CAHs, PPS, and All Wisconsin groups from 2000 through 2008.



Several clear conclusions can be surmised from this graph. The first is the increase in uncompensated care since 2005. Several factors may be contributing to this trend. One is the increase in uninsured or underinsured patients. Another may be changes in health insurance plans that lead to higher deductibles and coinsurance. Another clear trend in the graph is that since 2006, CAHs provide higher levels of uncompensated care compared to the average for Wisconsin hospitals. The graph indicates this is a result of higher than average Bad Debts. The economic strength of the communities CAHs serve may be contributing to the trend. Unfortunately, unless pending healthcare reform initiatives (see discussion in the “Recent Legislation” section) address this problem, Uncompensated Care costs for all providers may continue to rise.

Recently, legislation was considered that would hold hospitals more accountable for their tax-exempt status. The legislation would have required nonprofit hospitals to spend a minimum amount on charity care and also would have limited executive compensation and address conflicts of interest. Penalties would have been imposed on nonprofit hospitals that failed to meet the new

requirements. The penalties varied from taxes and fines to revoking the hospitals federal-tax exemption. The legislation would have required nonprofit hospitals to spend at least 5% of patient revenue on charity care. It is unclear as of the date of this study whether the charity care requirements will be included in the broader healthcare reform under consideration.

FUTURE OF CRITICAL ACCESS HOSPITALS

Because of changes in eligibility rules, most facilities who qualify to become CAHs have already converted. Therefore, it is unlikely the 1,300 CAHs are going to increase substantially. However, a challenge faces some CAHs who wish to build new facilities at a new location. According to CMS, CAHs that have been granted Necessary Provider status and want to rebuild in a new location that does not meet the distance requirements of the 35-mile rule will be treated in the same manner as if they were building a replacement facility at the previous location. The new facility will have to continue to meet the same criteria that led to its original state designation, serve at least 75% of the same service area, offer 75% of the same services, and utilize at least 75% of the same staff in its new location. CAHs need to carefully consider the impact on their status of any relocation decisions.

In the August 2007 study, the subject of hospital charges was a high priority. In response to this concern, charge data was made public by the WHA Information Center through its PricePoint website. Inpatient, Outpatient, and Emergency/Urgent Care charge information is available on the site. Although Wisconsin hospitals continue to report charge data, the issue of hospital charges appears to be less of a priority than two years ago.

Another test facing Wisconsin CAHs is HIT. Even with grant assistance, the costs to hospitals to implement new technology will be substantial. Balancing the capital needs to improve or replace aging facilities while also investing in new technology will be challenging.

Of the many problems facing Wisconsin CAHs, the struggling economy may be the greatest. Hospitals are uniquely affected by economic downturns because of the impact of consumer behavior due to unemployment and the possible resulting lack of insurance and personal resources. The Economic Crisis: the Toll on the Patients and Communities Hospitals Serve, dated April 27, 2009, by AHA summarizes the effect on hospitals of the weak economy. Hospitals are experiencing:

- Increasing emergency department patients without health insurance
- Increase in patients covered by public programs such as Medicaid
- Fewer patients seeking and more patients delaying elective care
- Decrease in charitable contributions

In addition, the Wisconsin Medical Assistance Program has recently announced plans to reduce reimbursement to CAHs by an average of 10%. CAHs, which on average, have higher Medical Assistance utilization than PPS hospitals in Wisconsin, will need to contend with a reduction in reimbursement that will further stress their financial condition.

According to the study, in order to address these economic concerns, 90% of hospitals have made cutbacks to address economic challenges. Some of the cutbacks hospitals have taken are:

- Reduced staff
- Administrative expense cuts
- Reduced services such as behavioral health, post acute care, clinic, patient education and other subsidized services

The report finds that in spite of these cutbacks, 70% of hospitals reported a decline in financial health which will impact their ability to provide for patients in their communities. 43% of hospitals expect losses in the first quarter of 2009. Also, 80% of hospitals have stopped, postponed or scaled back projects planned or already in progress. Hospitals have cut capital spending for facility upgrades, clinical technology and/or information technology. Also, according to the Bureau of Labor Statistics, hospital employment, typically thought to be immune from economic downturns, is no longer growing. The impact on jobs in rural Wisconsin is especially troublesome. A recent report from the University of Wisconsin Extension, Health Hospitals, Healthy Communities-The Economic Impact of Wisconsin's Hospitals, states hospitals are among the top 10 employers in 44 of 72 counties and among the top 5 employers in 20 counties.

The effect of hospital declining financial strength is obviously a concern to creditors. Under certain conditions, some creditors can require immediate repayment of borrowed money. Hospitals may also experience an increase in interest rates because of lower credit agency ratings. Indeed, access to capital may be significantly more difficult or even impossible because of the decrease in financial strength.

SUMMARY

The healthcare industry has been and continues to be very dynamic. CAHs have faced many challenges since the 2007 study. Growth in Medicare Advantage plans, uncompensated care concerns, technology demands, quality measurement data, government rules and legislation, and possibly the greatest challenge of all, a struggling economy. However, these challenges also present opportunities. The 2003, 2005, and 2007 studies indicated Wisconsin CAHs had improved their financial position. The 2009 study shows a more mixed result. The Average Age of Plant ratio has improved. The FSI ratio improved in 2007 but decreased in 2008. Stronger financial performance has resulted in access to capital and major investments in plant and equipment. Many CAHs, like PPS organizations, continue to invest in facilities, equipment and technology.

Because of the patient demographics in Wisconsin CAH communities, Medicare reimbursement has an acute impact on overall financial performance. However, here are several other contributing factors:

- Medical Staff
- Management and Board of Directors
- General financial strength of surrounding communities and service area
- Hospital staff
- Competition
- Strength of U.S. economy
- Quality of care
- Payers

Many factors contribute to the financial condition of any organization. It should be noted that although cost-based Medicare payment contributes to improved financial performance, in order to survive all facilities must generate positive operating margins. This leaves a relatively small number of payers to provide the income needed for costs not covered by Medicare such as care provided to non-insured or under-insured, capital needs in excess of depreciation, and working capital.

One of the goals of the CAH program was to improve financial performance and maintain access to quality local healthcare. Until recently, this goal appears to have been met. However with the struggling economy, will this progress continue? If not, what will be the impact on CAHs? Will CAHs be able to access the capital markets for much needed technology and facility improvements? The challenge for the future will be to build on the progress that has been made in spite of a weak economy. The goal for the next CAH financial performance study will be to determine if this challenge has been met.

OTHER RESOURCES

Here are several websites that have more information on CAHs:

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>
Health Resources and Services Administration www.hrsa.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/>