

The Financial Effects of Wisconsin Critical Access Hospital Conversion

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EXECUTIVE SUMMARY

Approximately one-half of the rural hospitals in the United States are now Critical Access Hospitals (CAHs). Wisconsin has over 50 as of the date of this study. The increase in the number of CAHs can be attributed in part to recent legislation which changed the criteria to qualify for the program. The purpose of this study is to analyze the financial condition of Wisconsin's 31 CAHs whose conversion date was prior to January 1, 2004. This study updated a previous analysis completed in 2003. Here are several observations from the analysis:

- The 17 facilities that converted prior to January 1, 2002, the "Early" group, generally were smaller and not as strong financially as those converting on or after January 1, 2002, through January 1, 2004, known as the "Later" group, which consists of 14 facilities.
- Both groups experienced improvements in several key financial ratios after conversion. Total margin, average age of plant, and the financial strength ratio all improved for both groups after conversion.
- Even though the study group has improved in several key financial performance ratios, the overall financial strength as measured by a ratio that combines several key performance indicators, shows the group at the bottom of the "Good" range.
- Many facilities have used their improved financial position to improve or replace outdated plants and equipment resulting in an average age of plant ratio that is more in line with industry standards.
- An analysis of services provided by the study group indicates an increase in some non-Medicare covered services and decreases in others. This would indicate, at least so far, that management decisions on which services to provide in their communities have been based on factors other than CAH status.

One of the main purposes of the CAH program was to improve the financial stability of small, rural facilities. Small, rural facilities were struggling with Medicare's Prospective Payment Systems (PPS). Payments to these institutions were inadequate because of low volumes and relatively high fixed costs. The financial deterioration of the hospitals resulted in a lack of investment in modern facilities and medical equipment. Some facilities closed and access to healthcare services became an issue in some areas. The CAH program has improved financial performance and access to capital. Capital investments will improve the CAHs ability to provide and expand needed health care services to their communities.

INTRODUCTION

The purpose of this study is to report on the financial impact of designation of Wisconsin hospitals as CAHs. A similar report was conducted in 2003. At the time the 2003 study was completed, the CAH program in Wisconsin was in the very early stages. The group of converted hospitals included in the 2003 study obviously now have more experience under the CAH payment methodology. Several hospitals were not included in the first study because they had been CAHs for only a short-period of time. This group of hospitals along with several who received CAH status since the first study will be included in this update. The facilities that we selected for this study are discussed in more detail in the Scope section of this report.

This report shows that:

- Total Margins have increased from just over 0.0% to slightly over 4.5% from 1998 by 2004.
- The “Later” CAH converters were relatively stronger before conversion in performance as measured by key financial ratios.
- Operating Margins have improved.
- Overall strength as measured by the Financial Strength Index has improved for both study groups.
- No discernable trends of adding or discontinuing patient services provided by the study group have been detected.

SCOPE OF STUDY

As of February 1, 2005, Wisconsin had 52 CAH facilities. Three additional hospitals have also filed Letters of Intent. The first Wisconsin hospital received CAH designation on October 1, 1999. One hospital that received CAH status in 1999 was included in the 2003 study but has since closed and will not be included in this update. Table 1 shows when Wisconsin hospitals received CAH status and the number of facilities that will be included in this update:

Table 1: Wisconsin Certified CAH Facilities

YEAR	Certified	2003 STUDY	SINCE 2003	TOTAL FOR STUDY
1999	2	3	(1)	2
2000	6	4	2	6
2001	9	9		9
2002	8		8	8
2003	6		6	6
2004	17			Not included in study
2005	4			Not included in study
	52	16	15	31

One 1999 hospital closed since the 2003 study. Two 2000 hospitals were excluded for 2003 because of lack of data but are included for this study.

There were 16 hospitals included in the 2003 study. One of those facilities has since closed. Two hospitals were excluded in 2003 due to lack of availability of financial data but will be included in this study. We evaluated 17 hospitals in the “Early” group to determine how CAH status continues to affect their financial performance. Obviously, the “Early” group had the most history under CAH payment methodology. We also evaluated the second tier of facilities (“Later”) which included those hospitals that received their CAH status in 2002 (8) or 2003 (6). We used this “Later” group of 14 because they have at least one reporting period as a CAH facility. In order to evaluate how these facilities are doing financially, we only used hospitals that received their CAH status on or before January 1, 2004. Finally, we combined all 31 facilities to evaluate how both groups’ performance has been impacted by conversion to CAH status.

It must be stated that data from the 2003 study group may vary in the 2005 update. This is due to a number of reasons. Formulas used to accumulate data and calculate ratios for the “Later” were improved and used for “Early” for consistency purposes. Also as mentioned, one CAH facility has closed since 2003 and is no longer part of the study and two facilities have been added. Data was also verified for the 2003 group and any errors or omissions were corrected. The assumptions and conclusions drawn from the 2003 analysis have not, however, changed in this study.

Another issue in accumulating data for ratio analysis concerns negative numbers. For example, several facilities had years in which they had net losses. Some also had years when they had negative equity. Even very small positive equity balances affected the ratio comparisons. In order to make valid comparisons between groups and years, ratios for some providers for some years were omitted. These omissions, however, did not affect the overall trends of the data or the assumptions one can conclude from the analysis. As mentioned previously, the purpose of the study is to evaluate the impact that CAH status has had on these hospitals from a financial and operational standpoint. Two caveats to the study must be stated. It is still very early in the history of the CAH program to draw conclusions with absolute certainty. The other issue is that the Wisconsin CAH group is relatively small. It would be imprudent to apply assumptions for this group to any others.

To complete our study, we requested specific data from the hospitals involved. We also accessed data available to us through other means. Information was also provided by the Wisconsin Office of Rural Health, the Wisconsin Hospital Association-Information Center, the Center for Medicare and Medicaid Services, and the Wisconsin Department of Health & Family Services. One source of data for the study was Medicare cost reports. Another was the hospital’s audited financial statements. In some cases, internal unaudited statements were used. The financial information was grouped in the calendar year depending on the ending date of the cost report. In other words, if a cost report covered the period from July 1, 2000, through June 30, 2001, the information was included in the 2001 year. Cost reports for 2004 for facilities with fiscal years ending December 31 were not included because Medicare does require these reports to be filed until May 31, 2005. Because of short period cost reports, some hospitals had two cost reports ending in a single year. In those situations, the Prospective Payment System (PPS) report information was included with the PPS data and the CAH cost report was included with the CAH financial data. Some hospitals also changed their fiscal years during the time period covered for this study. No projections or estimates of future performance were used for this project. The original study was completed in the spring of 2003 with this update completed in the spring of 2005.

REIMBURSEMENT CHANGES

Under PPS, inpatient reimbursement is based on diagnostic 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-based 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. CAH facilities 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. Table 2 indicates the changes in reimbursement experienced by the 31 facilities included in this study. Table 2 shows the failure of PPS reimbursement for this type of facility.

During the years preceding any of the hospitals included in the study becoming a CAH, this group of hospitals was experiencing Medicare reimbursement that was less than the cost of the services provided. In order for the ratios to be consistent for PPS and CAH payment systems, outpatient costs, payments, and charges in Table 2 does not include data for Medicare outpatient laboratory services. Under the PPS system, most Medicare outpatient laboratory tests are paid based on a fee schedule. CAH facilities are paid costs for Medicare outpatient laboratory services. In general, Medicare laboratory fee schedule reimbursement is less than cost. For 2004, all facilities had converted to CAH status resulting in Medicare payments equaling cost.

Table 2: Medicare Acute, Swing Bed, and Outpatient Costs & Payments

Description	1997	1998	1999	2000	2001	2002	2003	2004
ALL FACILITIES								
Medicare Reimbursement								
Inpatient								
Acute Care Payment/Costs	97.56%	95.11%	92.51%	92.21%	91.73%	93.44%	95.47%	100.00%
Swing Bed Payment/Costs	36.78%	36.21%	36.28%	36.15%	50.44%	77.64%	85.45%	100.00%
Swing Bed Costs Per Day	\$251.73	\$266.23	\$295.31	\$307.77	\$454.95	\$717.99	\$889.50	\$1,022.19
Outpatient								
O/P % Costs to Charges	58.42%	55.70%	54.09%	52.61%	52.44%	52.73%	53.62%	51.47%
O/P % Payment to Charges	51.46%	49.25%	46.95%	45.71%	46.27%	48.94%	51.76%	51.47%

In Wisconsin, CAHs also receive Medicaid reimbursement based on Medicare cost principles. As a result, Wisconsin CAHs have also received an increase in reimbursement from the Medicaid program.

FINANCIAL PERFORMANCE ANALYSIS

As with the 2003 study, ratio analysis will be used to evaluate financial performance. A discussion of key ratios selected for this project follows.

Table 3: Financial Ratios & Descriptions

RATIO	DESCRIPTION
Current Ratio	This ratio measures the hospital's ability to meet its current liabilities with its current assets (assets expected to be realized in cash during the fiscal year). A ratio of 1.0 or higher indicates that all current liabilities could be adequately covered by the hospital's existing current assets.
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.
Total Margin	This ratio evaluates the overall profitability of the hospital using both operating surplus (loss) and non-operating surplus (loss).
Return on Equity	Expression of net income relative to total equity.
Average Age of Plant	Age of plant is the average age of property, plant and equipment owned by the hospital.
Debt Financing Percent	Measures relationship of debts to assets.
Fixed Asset Turnover	Provides an indication of the efficiency with which the hospital uses its fixed assets to generate revenues.
Long-Term Debt to Equity	Measures hospital's burden of debt and the ability for additional borrowing.
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
Current Ratio	Current assets/Current liabilities
Days in Accounts Receivable (net)	Net accounts receivable/Net patient revenue per day
Days' Cash on Hand	Cash/(Operating expenses less depreciation/365)
Total Margin	Excess of revenue over expenses/Total revenue
Return on Equity	Excess of revenues over expenses/Net Assets
Average Age of Plant	Accumulated depreciation/Depreciation expense
Debt Financing Percent	Total liabilities/Total assets
Fixed Asset Turnover	Total revenue/Net plant, property and equipment
Long-Term Debt to Equity	Total long-term debt/Net assets
Deduction Ratio	Total patient revenue-net patient revenue/Total patient revenue
Financial Strength Index	See discussion below

The financial strength index (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.

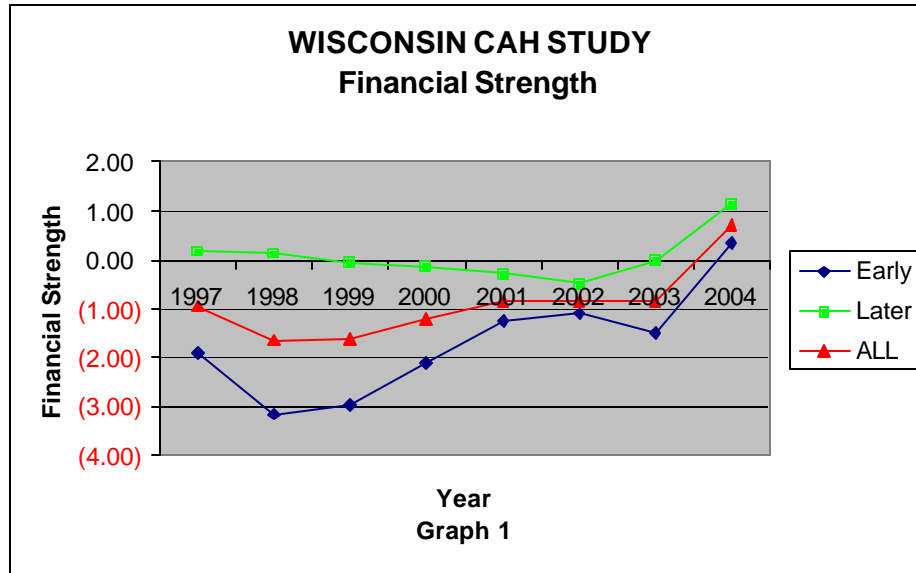
Table 6: FSI Rating Guide

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 day’s 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

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*.

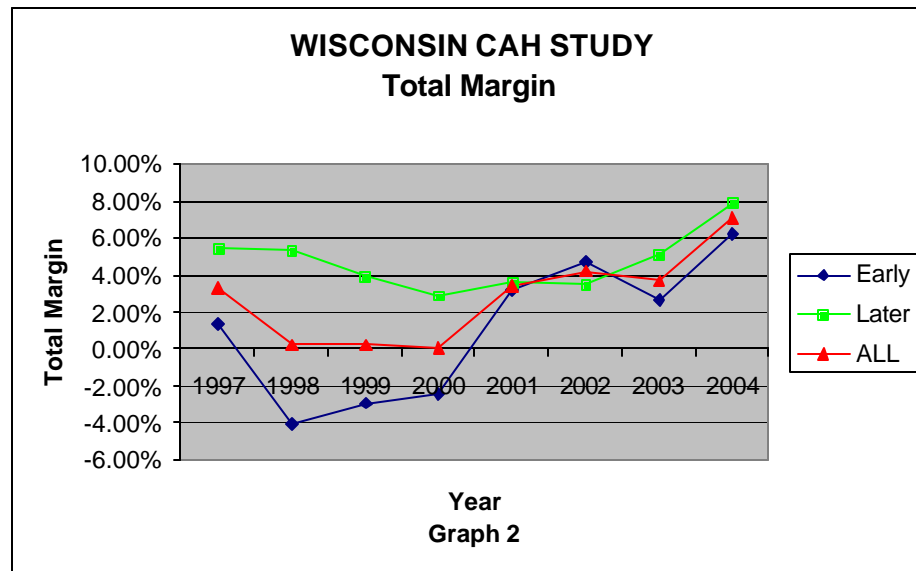
The 2003 study showed a slight improvement in the Financial Strength ratio. Graph 1 below continues to show improvement:



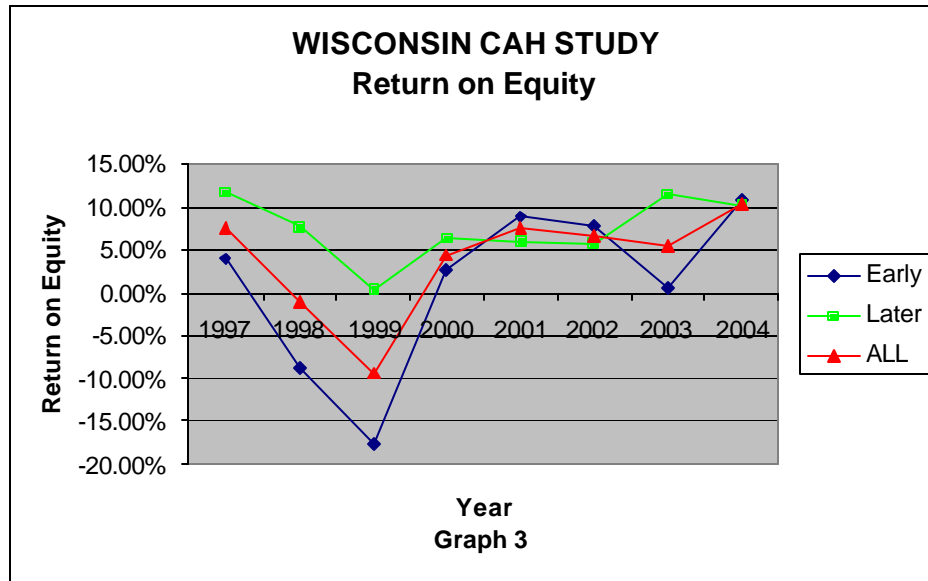
The graph shows that “Early” facilities generally had lower Financial Strength ratios than the CAH converters in “Later”. Both groups showed similar improvements in this ratio. When both Groups are combined, the 2004 Financial Strength ratio is .74. Per the rating guide in Table 6, this financial strength rating puts the study group just above the “Fair” range and at the low end of the “Good” range of financial health.

SUMMARY OF FINANCIAL IMPACT

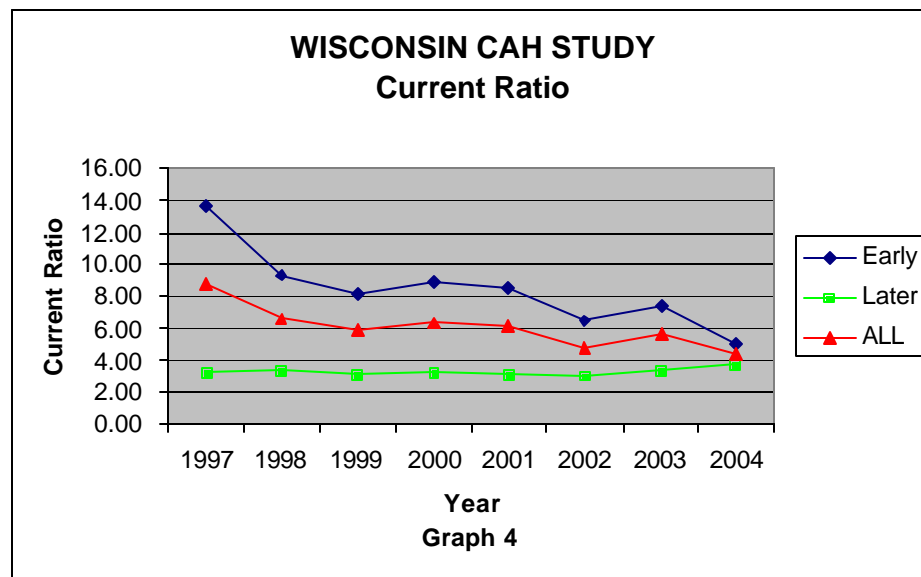
Early indications from the 2003 study showed that the financial impact on CAHs had been generally positive. The updated analysis of various ratios indicates continued improvement in financial performance in a number of key areas.



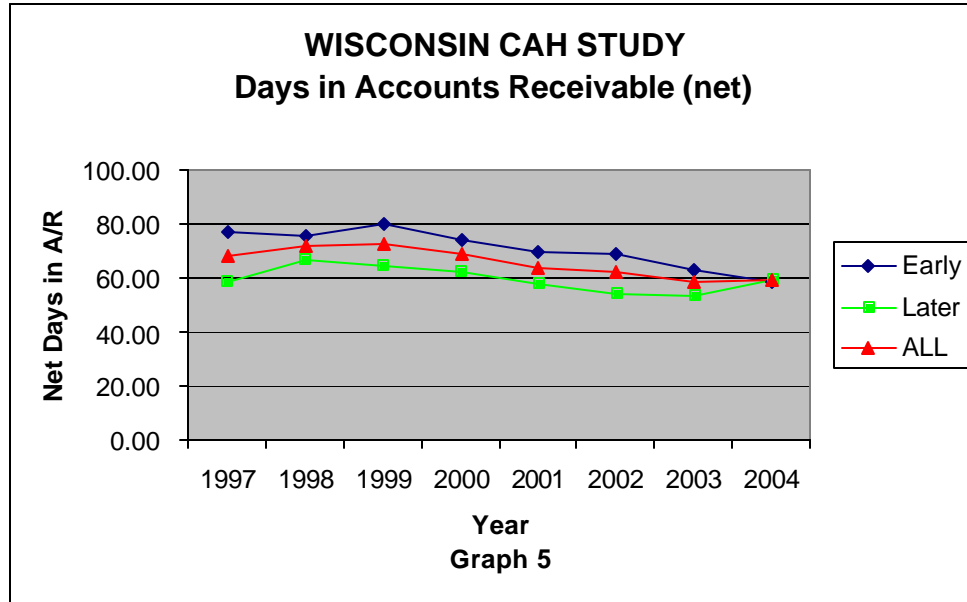
As indicated in Table 4, Total Margin represents the percent of Net Income to Net Patient Revenue. High Total Margin percentages and increasing trends are favorable financial indicators. Graph 2 shows that in 1998, 1999, and 2000, all study group hospitals total margin was just over 0.00% percent. The graph shows that hospitals were struggling under Medicare PPS to remain profitable. By 2001, total margin had risen to 4% and by 2004 was in a range that is conducive to overall financial strength. The graph also indicates that the “Early” converters to CAH status had lower total margins than the “Later” facilities.



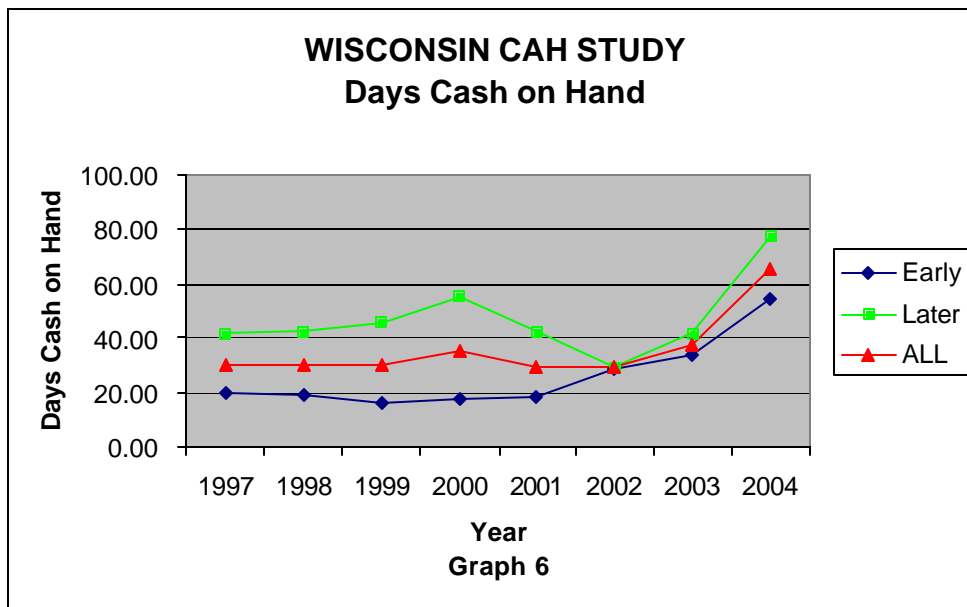
Another financial ratio related closely to Total Margin is Return on Equity. This ratio is calculated by dividing Net Income by Equity. Equity is also referred to as “Net Assets” which is Total Assets minus Liabilities. Graph 3 again shows declining Returns on Equity for 1998 and 1999 under PPS. The graph shows Return on Equity started improving in 2000. Once again, it is clear that the “Later” facilities had higher return on equity than “Early”.



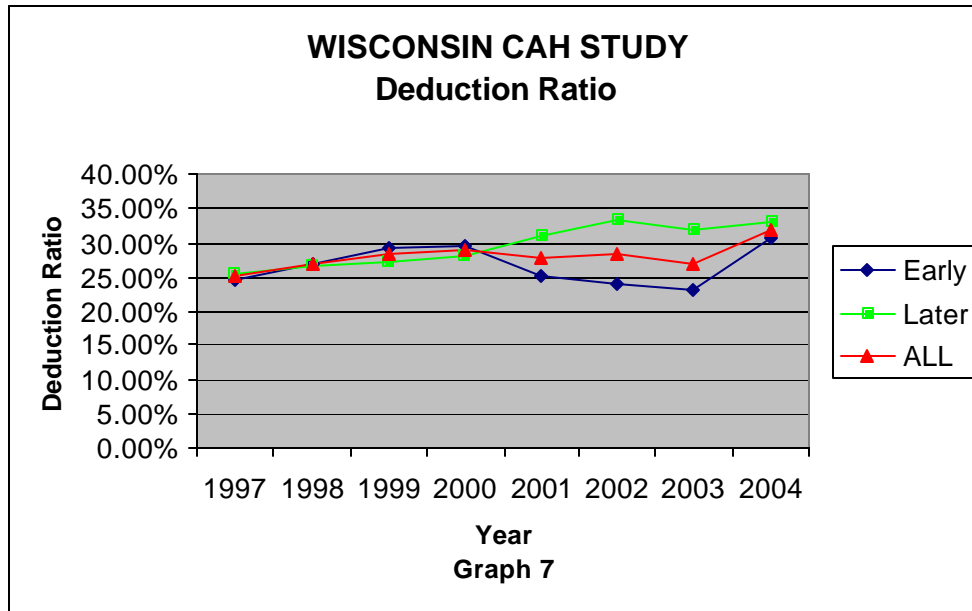
Graph 4 shows the ratio of current assets to current liabilities. Current assets are those assets of a company that are reasonably expected to be realized in cash, or sold, or consumed during the normal operating cycle of the business (usually one year). Such assets include cash, accounts receivable due usually within one year, short-term investments, inventories, and prepaid expenses. Current liabilities are liabilities to be paid within one year of the balance sheet date. Increasing trends for the Current Ratio is favorable. “Early” facilities generally have higher current ratios than the “Later” hospitals. “Early” facilities’ current ratio dropped in 2004.



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 Days in Accounts Receivable usually translates into higher cash account balances. The study group has showed a general improvement in collecting accounts receivable since 1999, as shown in Graph 5.



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. Graph 6 indicates that in 2000, "Later" had higher Days' Cash on Hand than "Early". In 2002 both groups had about the same days' cash on hand. However, in 2004, the "Later" again showed higher days' cash on hand than "Early". As mentioned in the Days in Accounts Receivable, effective management of accounts receivable has a positive impact on Days' Cash on Hand.



The deduction ratio shows the percent difference between hospital charges and actual cash paid for services provided. The deductions include government payers such as Medicare and Medicaid, Health Maintenance Organizations, Preferred Provider Organizations, and private pay discounts (charity care). For 1998, 1999, and 2000, Graph 7 reflects a growing gap between hospital "gross" charges and the "net" charges for services provided. As the study group converts to CAH status, the deduction ratio for "All" facilities actually declines for 2003 but increases in 2004. This trend can be attributed to increased payment under CAH status. Increases in Medicare payments impact this ratio due to the group's high percentage of Medicare patients (see Table 7 below) than the national average for acute care hospitals of approximately 35%. Since the conversion to CAH status reduced discounts to the Medicare and Medicaid programs, non-government payers are now receiving higher discounts.

Table 7: Medicare Utilization (Based on Patient Days)

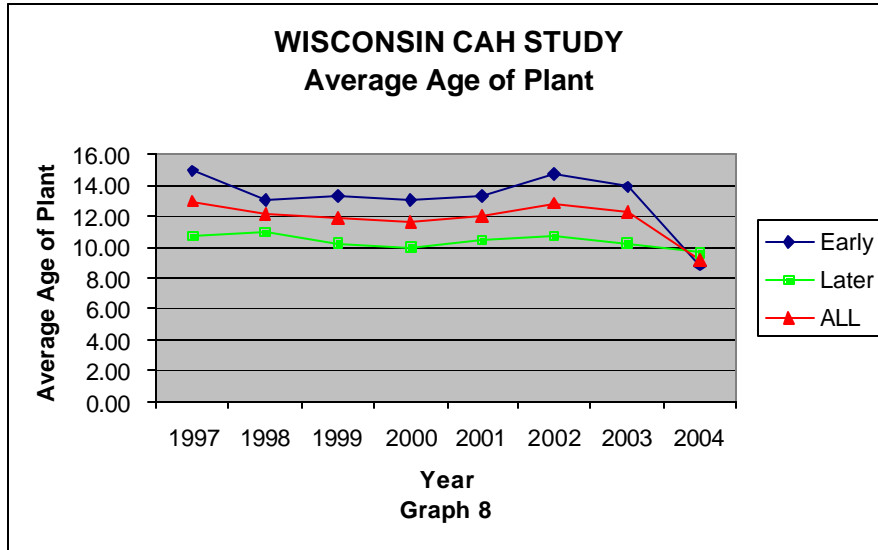
Year	1997	1998	1999	2000	2001	2002	2003	2004
Utilization	75.41%	76.33%	75.16%	74.48%	73.72%	75.69%	77.04%	77.09%

ACCESS TO CAPITAL MARKETS

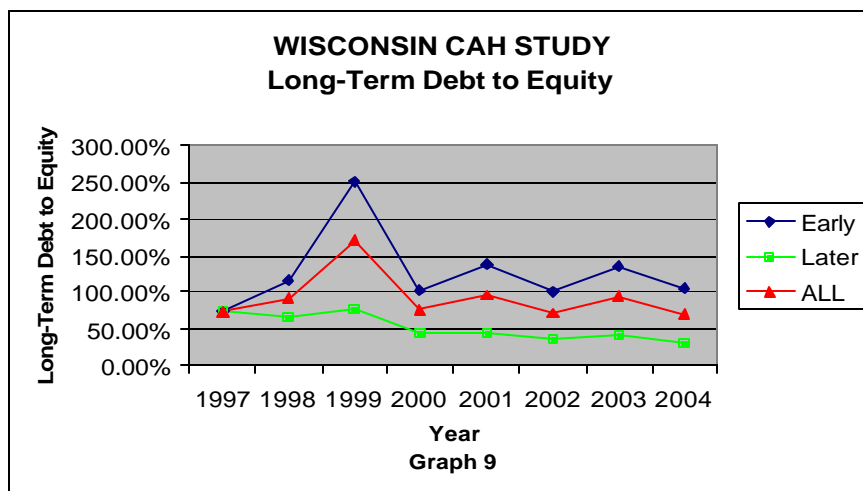
One of the benefits to improved financial performance under CAH status is the improved access to capital markets. Rural hospitals generally have struggled to replace outdated facilities and equipment under the PPS payment system. Many articles have been written on this crucial issue. A briefing paper titled, "The Availability and Use of Capital by Critical Access Hospitals," in March of 2005 by the Flex Monitoring Team by the University of Minnesota, the University of

North Carolina at Chapel Hill, and the University of Southern Maine is an excellent resource on this problem. The authors of this paper conclude that CAH status “may provide significant advantages for small rural hospitals in search of capital.” However, it also suggests that “this advantage is *not* (emphasis added) enough to close the gap in capital needs generated by efforts to control rising health care costs, improve quality, enhance access, and foster greater commitment and effort toward performance improvement for the hospital industry.”

Four capital-related ratios for the study confirm the findings of the study mentioned above. The ratios are average age of plant, long-term debt to equity, debt-financing percent, and fixed asset turnover.

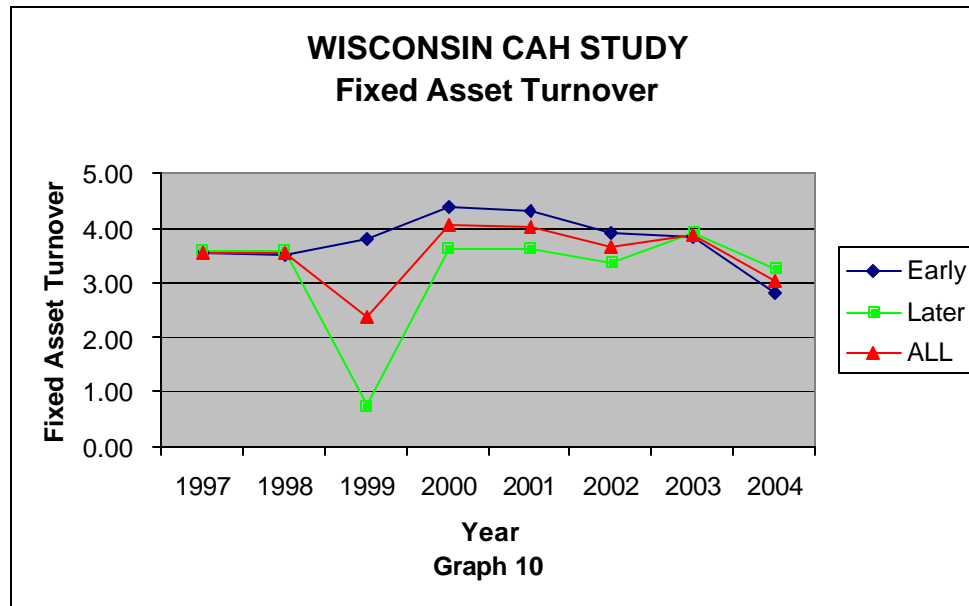


Average Age of Plant is calculated by dividing Accumulated Depreciation by Depreciation Expense. Lower ratios are favorable as are decreasing trends. The chart shows a decline in average age of plant ratios for both groups for 2003 and 2004. This would indicate that capital improvements have been made since CAH conversions. It is generally felt that average age of plant should be less than 10.0, and many feel that it should be closer to 7.5. This graph indicates that CAH facilities have used their CAH status to provide long overdue improvements to their facilities.



Long Term Debt to Equity ratio is long term debt divided by “Equity” also referred to “Net Assets”. This ratio measures the entities’ burden of long-term debt and the ability to borrow additional funds. Low values are favorable.

In 1999, both groups experienced increases in long-term debt to equity. CAH status has allowed facilities to generally increase income and equity thereby reducing this ratio since then.



The Fixed Asset Turnover ratio is calculated by dividing gross revenue by the book value of property and equipment less accumulated depreciation. Higher ratios are favorable. Higher Fixed Asset Turnover ratios indicate assets are used more efficiently to provide patient services. Both “Early” and “Later” showed increases in the fixed asset turnover ratio in 2000. The decrease in this ratio in 2004 may be caused by an increase in the book value of property and equipment due to increased capital improvement projects.

CHANGES IN SERVICES

As mentioned previously, CAH facilities are reimbursed the cost they incur for services provided to Medicare beneficiaries. Table 7 shows the Medicare utilization for the study facilities for the indicated years based on Medicare patient days to total facility patient days. The impact on Medicare payments is a factor for CAH facilities in deciding which services to provide.

Table 8, which follows, shows a number of common patient healthcare services. The table indicates what services are provided at 28 of the CAH facilities for the years 1997 through 2003.

Table 8

SERVICE (28 HOSPITALS REPORTING)	1997	1998	1999	2000	2001	2002	2003
ADULT MEDICAL/SURGICAL, ACUTE	28	28	28	28	28	28	28
ORTHOPEDIC	20	21	23	23	24	23	22
REHABILITATION AND PHYSICAL MEDICINE	13	14	14	14	14	15	14
HOSPICE	12	13	16	15	14	13	13

SERVICE (28 HOSPITALS REPORTING)	1997	1998	1999	2000	2001	2002	2003
NURSING HOME (SNF'S)	15	15	15	15	15	15	15
ALL OTHER ACUTE	1	1	2	2	2	2	4
PEDIATRICS	26	26	27	26	26	27	26
OBSTETRICS	21	20	20	19	19	18	17
PSYCHIATRIC	2	4	1	1	1	1	2
ALCOHOLISM/CHEMICAL DEPENDENCY	6	6	5	6	6	6	6
MEDICAL/SURGICAL INTENSIVE CARE	17	16	16	15	15	15	14
CARDIAC INTENSIVE CARE	15	14	13	12	12	12	9
PEDIATRIC INTENSIVE CARE	7	6	4	4	4	3	3
BURN CARE	1	1	1	2	3	3	2
MIXED INTENSIVE CARE	13	13	13	13	11	12	10
STEP-DOWN	6	7	8	9	9	8	5
ALL OTHER INTENSIVE CARE	1	2	2	2	2	1	0
SUBACUTE CARE	4	5	6	6	6	6	7
ALL OTHER INPATIENT UNITS	3	3	5	3	4	4	4
MEDICARE CERTIFIED SWING UNITS	28	28	28	28	27	28	27
NEWBORN NURSERY	21	20	20	19	19	18	16
ALCOHOLISM/CHEMICAL DEPENDENCY OUTPATIENT SERVICES	2	2	2	2	2	1	1
NONEMERGENCY TRANSPORTS BY GROUND AMBULANCE	7	6	6	6	6	6	6
ARTHRITIS TREATMENT CENTER	1	0	0	0	0	0	0
ASSISTED LIVING	4	3	3	3	3	3	5
LABOR, DELIVERY POSTPARTUM ROOM	20	20	20	19	20	18	17
CARDIAC REHABILITATION PROGRAM	23	26	25	25	25	25	24
NONINVASIVE CARDIAC ASSESSMENT SERVICES	19	21	19	19	19	19	20
CASE MANAGEMENT	11	12	14	16	15	16	17
CRISIS PREVENTION	1	1	1	1	1	0	1
HEMODIALYSIS	3	3	2	2	2	2	2
EMERGENCY DEPARTMENT (GENERAL MEDICAL AND SURGICAL)	26	28	28	28	28	28	28
TRAUMA CENTER	6	7	8	8	8	9	9
URGENT CARE CENTER	10	14	15	18	18	17	17
ETHICS COMMITTEE	20	20	21	23	23	23	22
EXTRACORPOREAL SHOCK WAVE LITHOTRIPTER	0	0	0	0	0	0	1
FITNESS CENTER	5	6	8	7	7	7	6
MEALS ON WHEELS	9	10	10	12	12	12	13
NUTRITION PROGRAMS	19	21	22	24	24	24	23
GENETIC COUNSELING/SCREENING	1	1	0	0	0	0	0
ADULT DAYCARE PROGRAM	7	7	6	6	5	5	5
ALZHEIMER'S DIAGNOSIS/ASSESSMENT	5	5	4	4	4	4	3
COMPREHENSIVE GERIATRIC ASSESSMENT	7	7	6	5	5	6	5
EMERGENCY RESPONSE SYSTEM	16	16	15	14	13	12	12
GERIATRIC ACUTE CARE UNIT	7	6	6	6	6	5	5
GERIATRIC CLINICS	2	1	1	1	1	1	2
RESPIRE CARE	24	23	21	22	21	22	22
RETIREMENT HOUSING	4	4	4	4	5	6	7
SENIOR MEMBERSHIP PROGRAM	1	1	2	2	2	2	2
COMMUNITY HEALTH PROMOTION	25	25	27	27	27	27	26
PATIENT EDUCATION	27	26	27	27	27	27	26
WORKSITE HEALTH PROMOTION	22	22	23	23	23	22	22

SERVICE (28 HOSPITALS REPORTING)	1997	1998	1999	2000	2001	2002	2003
HOME HEALTH SERVICES	8	7	6	6	6	6	5
HOME HOSPICE SERVICES	4	4	4	4	4	4	3
DIAGNOSTIC MAMMOGRAPHY	25	25	26	25	25	26	24
MAMMOGRAPHY SCREENING	24	24	26	26	26	26	25
OCCUPATIONAL HEALTH SERVICES	20	20	20	20	20	21	21
AUDIOLOGY	12	13	14	12	12	10	10
OCCUPATIONAL THERAPY	18	21	22	22	22	23	24
PHYSICAL THERAPY	26	27	27	28	28	28	28
RECREATIONAL THERAPY	12	12	12	11	11	13	14
REHABILITATION INPATIENT SERVICES	17	16	17	18	18	18	22
REHABILITATION OUTPATIENT SERVICES	23	23	22	23	23	24	23
RESPIRATORY THERAPY	24	24	24	24	24	23	25
SPEECH PATHOLOGY/THERAPY	11	12	15	13	15	15	18
ONCOLOGY SERVICES	10	10	8	7	8	9	12
OUTPATIENT SERVICES-WITHIN THE HOSPITAL	28	27	28	28	28	28	28
OUTPATIENT SERVICES - ON HOSPITAL CAMPUS, IN FREESTANDING CTR	1	2	1	1	2	4	5
OUTPATIENT SERVICES - FREESTANDING OFF HOSPITAL CAMPUS	6	6	5	5	5	6	5
PATIENT REPRESENTATIVE SERVICES	17	17	19	19	20	20	20
PSYCHIATRIC CHILD/ADOLESCENT SERVICES	2	1	1	1	1	1	0
PSYCHIATRIC CONSULTATION-LIASON SERVICES	3	2	3	2	2	2	1
PSYCHIATRIC EDUCATION SERVICES	1	1	1	1	1	1	0
PSYCHIATRIC EMERGENCY SERVICES	6	6	5	5	5	5	4
PSYCHIATRIC GERATRIC SERVICES	1	3	2	1	1	1	0
PSYCHIATRIC OUTPATIENT SERVICES	3	3	3	3	3	3	2
PSYCHIATRIC PARTIAL HOSPITALIZATION PROGRAM	1	2	1	1	1	1	1
CT SCANNER	21	21	23	24	26	27	27
DIAGNOSTIC RADIOISOTOPE FACILTY	5	5	7	8	8	6	7
MAGNETIC RESONANCE IMAGING	1	1	3	6	6	5	6
SINGLE POSITION EMISSION TOMOGRAPHY SCANNER	1	0	1	1	1	1	1
ULTRASOUND	13	14	16	18	18	18	17
SOCIAL WORK SERVICES	25	26	25	25	25	24	25
SPORTS MEDICINE CLINIC/SERVICES	13	14	15	16	17	18	19
SURGERY, AMBULATORY OR OUTPATIENT (DAY SURGERY)	28	27	27	27	27	27	27
WOMEN'S HEALTH CENTER/SERVICES	5	5	4	4	4	5	4
NUMBER OF OTHER LOCATIONS	8	9	8	9	8	5	8
NUMBER OF CLINICS THAT USE HOSPITAL'S MEDICARE PROVIDER #	3	4	4	3	4	5	8
MEDICAL SPECIALTIES -TOTAL	502	526	493	555	533	552	502
BOARD CERTIFIED STAFF-TOTAL	419	419	409	462	444	451	402
SOURCE: State of Wisconsin Annual Survey of Hospitals							
Service only counted if provided in or by the hospital							

It is difficult to extrapolate any service trends from Table 8 as directly related to conversion to CAH status. Some programs that are not Medicare reimbursable have actually increased (Meals on Wheels). The decline of Newborn services from 21 hospitals in 1997 to only 16 in 2003 may relate to this being a non-Medicare patient related service. The success of most institutions is closely related to its ability to maintain Medical Staff. Table 8 shows Total Medical Specialties physicians increased from 502 in 1997 to 552 in 2002 but then dropped back down to 502 in 2003. Board certified staff showed a similar trend. More study facilities provide high cost diagnostic testing such as CT Scanners and Magnetic Resonance Imaging in 2003 than they did in 1997.

Hospitals may change services for a number of reasons unrelated to CAH status. Management is charged with the responsibility of determining which services to provide. National studies indicate CAH hospitals are adapting to cost-based payment by expanding services such as swing beds, radiological services, outpatient rehabilitation, and rural health clinics. Services that are the most likely to be eliminated are home health and obstetrics.

LEGISLATIVE CHANGES

There have been significant recent legislative changes to the CAH program. On December 8, 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) became law. This law contains important provisions for CAHs that increase payments, expand bed size flexibility, continue funding of the Medicare Rural Hospital Flexibility Program grants (Flex Grants) and clarifies or improves other aspects of the CAH program. The law also created the Medicare Advantage program.

Revision of Bed Limitation for Hospitals

Under previous law, a CAH could operate only 25 beds and was limited to 15 acute care beds and 10 swing beds. MMA removed this limitation and permits CAHs to operate up to a total of 25 beds which can be used interchangeably for acute care or swing-bed services. The provision applies to CAH designations made before, on or after January 1, 2004. However, the provision will apply prospectively for any election made after regulations for this provision have been promulgated.

Increased Payment Amounts

Prior to the MMA, CAHs received reasonable cost reimbursement and could elect either a cost-based hospital outpatient service reimbursement or an all-inclusive rate (Method II, see further discussion below), equal to a reasonable cost reimbursement for facility services plus 115% of the Medicare fee schedule for professional services. The new legislation pays CAHs at 101% of reasonable costs for Medicare inpatient, outpatient, and swing bed services furnished during cost reporting periods beginning on or after January 1, 2004.

Special Professional Service Payment Adjustment (Method II)

Under previous law, a CAH could elect to be paid for outpatient services using cost-based reimbursement for its facility fee and at 115% of the Medicare fee schedule (Method II) for professional services otherwise included within its outpatient services for cost reporting periods

starting on or after October 1, 2000, if the CAH had obtained billing rights and billed for all professional services rendered in the outpatient setting.

Under the MMA legislation, it is no longer required that all physicians or practitioners providing services in a CAH assign their billing rights with respect to such services. For those who elect Method II, CAHs will be paid for outpatient services at 115% of the Medicare fee schedule for professional services performed in conjunction with their outpatient services. This amendment applies to cost reporting periods beginning on or after July 1, 2004. In the case of CAHs that made an election before November 1, 2003, the amendment applies to cost reporting periods beginning on or after July 1, 2001.

CAHs may elect payment under either the Standard Payment Method or the Optional (Elective) Payment Method. If the Optional Payment Method is chosen, the election remains in effect for the entire cost reporting period and applies to all CAH services furnished in the CAH outpatient department during that period. To make a new election or change a previous election, CAHs must notify their Fiscal Intermediary at least 30 days in advance of the affected cost reporting period.

Standard Payment Method—Cost-Based Facility Services with Billing of Carrier for Professional Services

CAHs will be paid under this method unless they elect to be paid under the Optional Payment Method. For cost reporting periods beginning on or after January 1, 2004, outpatient CAH services payments have been increased to the lesser of:

- 80% of the 101% of reasonable costs for CAH services, which is up from 100% of reasonable costs for CAH services OR
- 101% of the reasonable cost of the CAH in furnishing CAH services less the applicable Part B deductible and coinsurance amounts.

All the facilities for the cost reporting periods included in this study bill for professional outpatient services using the standard payment method.

Optional (Elective) Payment Method—Cost-Based Facility Services Plus 115% Fee Schedule Payment for Professional Services

As of January 1, 2004, payment for outpatient CAH services is based on the sum of:

- The lesser of 80% of 101% of the reasonable cost of the CAH in furnishing CAH services OR
- 101% of the outpatient services less applicable Part B deductible and coinsurance amounts AND
- 115% of the allowable amount after applicable deductions under the Medicare Physician Fee Schedule for physician professional services. Payment for non-physician practitioner professional services is 115% of 85% of the allowable amount under the Medicare Physician Fee Schedule.

Recently, several Wisconsin CAH facilities have converted to the Method II billing method. Because of the additional reimbursement, it is expected that more hospitals will switch to the Optional Payment Method in the future.

Psychiatric and Rehabilitation Distinct Part Units

Under previous law, beds in distinct part psychiatric or rehabilitation units (DPUs) operated by an entity seeking to become a CAH counted towards the bed limit.

MMA allowed CAHs to operate up to 10 psychiatric or rehabilitation distinct part beds for cost reporting periods beginning on or after October 1, 2004. Beds in the DPUs shall not count toward the CAH bed limit of 25. The amount of payment for inpatient CAH services shall be equal to that which otherwise would be made if such services were inpatient services of a hospital DPU. Therefore, psychiatric services are paid under TEFRA (until Medicare converts to prospective payment) and rehab services are paid under PPS.

Coverage of Costs for Certain Emergency On-Call Providers

The MMA expanded cost-based reimbursement of on-call emergency room physicians to include physician assistants, nurse practitioners, and clinical nurse specialists for costs incurred for covered Medicare services furnished on or after January 1, 2005.

Periodic Interim Payments

Periodic Interim Payments (PIP) are based on estimated annual costs without regard to the submission of individual claims. At the end of the year, a settlement is made to account for any differences between the estimated PIP and the actual amount owed. Previous to the MMA, CAHs were not eligible for PIP. Effective for payments made on or after July 1, 2004, CAHs can receive PIP.

Medicare Advantage

Medicare Advantage brings the most significant changes to Medicare since its inception. The program creates opportunities for increased access and services to Medicare beneficiaries, but major changes to Medicare in the past have hit rural providers hard.

Medicare Advantage offers beneficiaries choices as to how they will receive Medicare benefits, one of which is the traditional Medicare program. To the extent that beneficiaries choose an option other than traditional Medicare, the benefits that CAHs receive will become more a matter of negotiation than regulatory requirement. Rural facilities often lack the negotiating power of larger urban facilities, and therefore can be at a disadvantage when negotiating a contract with one of the new Medicare Advantage plans.

Waiver Authority—35-mile Rule

Under previous law, a CAH had to be located more than 35 miles from another hospital, or 15 miles in areas with mountainous terrain, or areas where only secondary roads are available. The mileage standards could be waived if the hospital had been designated by the state as a “necessary provider” of health care.

Beginning January 1, 2006, states no longer have the authority to “certify” hospitals as necessary providers. Hospitals so designated prior to January 1, 2006, are grandfathered.

A hospital must meet the following criteria to be designated as a CAH:

- Located in a rural area
- Provide 24-hour emergency care services
- Average length of stay of 96 hours or less
- More than 35 miles from a hospital or another CAH or more than 15 miles in areas with mountainous terrain or only secondary roads OR certified by the state as being a “necessary provider” of healthcare services to residents in the area

Effective January 1, 2006, the provision permitting a state to waive the distance requirements for CAH status via state “necessary provider” designation will sunset. Providers with CAH status as “necessary providers” via state designation prior to January 1, 2006, will be grandfathered as CAHs on and after January 1, 2006. Beginning on January 1, 2004, CAHs may operate up to 25 beds for acute (hospital level) inpatient care, subject to the 96-hour average length of stay for acute care patients. For CAHs with swing bed agreements, any of its beds may be used to furnish either inpatient acute care or swing bed services. Prior to January 1, 2004, CAHs could not operate more than 15 acute care beds or more than 25 beds if it included up to 10 swing beds. Medicare pays CAHs for inpatient and outpatient services on the basis of their current Medicare-allowable costs or “cost-based reimbursement” and are paid cost for ambulance services if they are the only ambulance supplier within 35 miles. CAHs are exempt from the inpatient and outpatient prospective payment systems.

Medicare Rural Hospital Flexibility Grants (Flex Grants)

Current law allows the HHS Secretary to administer the Medicare Rural Hospital Flexibility Program grants (Flex Grants) to states for rural health care planning and implementation activities, for rural network development and implementation, to establish or expand rural emergency medical services, and for CAH designations.

The new legislation extended funding of Flex Grants of \$35 million each year from FY 2005 through FY 2008. It also required that states receiving the grants consult with the state hospital association and rural hospitals on the most appropriate ways to use grant funds. It imposed limitations on use of grant funds for administrative expenses. Under the new grant guidelines, a state may expend up to the lesser of 15% of the grant amount or the state’s federally negotiated indirect rate for administering the grant. Beginning with FY 2005, up to 5% of the total amount appropriated for grants will be available to the Health Resources & Services Administration for administering these grants.

Summary of Legislative Changes

In summary, the legislative changes for CAHs are:

- CAHs permitted to operate up to a total of 25 beds which can be used interchangeably for acute care or swing-bed services.
- For cost reporting periods beginning on or after January 1, 2004, reimbursement for services furnished will be based on 101% of the CAH's reasonable costs, up from 100% of reasonable costs.
- For cost reporting periods beginning on and after July 1, 2004, each physician or other practitioner providing professional services in the hospital are not required to reassign their Part B benefits to the CAH in order for the CAH to select the Optional Payment Method.
- For cost reporting periods beginning on or after October 1, 2004, CAHs may establish psychiatric units and rehabilitation units that are distinct parts (DP) of the hospital. The total number of beds in each CAH DP may not exceed ten. These beds will not count against the CAH inpatient bed limit.
- For services furnished on or after January 1, 2005, cost-based reimbursement is extended to physician assistants, nurse practitioners, and certified nurse specialists who are on-call emergency room providers.
- Periodic interim payments will be paid every two weeks for CAH inpatient services furnished on or after July 1, 2004.
- Medicare Advantage will bring changes that may minimize the benefits that CAH status provides.
- Beginning January 1, 2006, states no longer have the authority to "certify" hospitals as necessary providers. Hospitals so designated prior to January 1, 2006, are grandfathered.
- The Medicare Rural Hospital Flexibility Program has been reauthorized to make grants to all states in the amount of \$35 million in each of fiscal years 2005 through 2008.

FUTURE OF THE CAH PROGRAM

The Medicare Payment Advisory Council (MEDPAC) at a recent meeting discussed the CAH program. According to the public minutes of the meeting, some members expressed concern over the rapid growth of the program. Other members indicated the program was fulfilling the intention of Congress of strengthening financial performance of qualifying facilities. One area of concern expressed was the possible incentives CAHs might have to limit charity care. A review of the 31 study hospitals indicates that the percent of uncompensated health care charges (bad debts and charity care) provided in 2000, 2001, 2002 was 2.86%, 3.02%, and 3.09% respectively. This analysis indicates that CAH status has had very little impact on the amount of uncompensated care provided by this group. Although it is still early in the life of the CAH program, policymakers will continue to review data and discuss ways to ensure the program is focused appropriately and opportunities for abuses are eliminated.

Although Medicare managed care plans have been available for a number of years, the MMA renamed this concept Medicare Advantage. CMS is investing significant funds and providing incentives to Medicare beneficiaries to enroll in these programs. Many rural hospital trade organizations have expressed concern that the protections afforded CAH facilities under the traditional Medicare program are not required to be included in contracts between CAHs and the managed care contractors. If managed care companies enroll significant numbers of rural beneficiaries in the Medicare Advantage program, the negative financial impact on CAHs could be severe. Legislation has been introduced to require CAH provider payment provisions under “fee-for-service” Medicare and Medicare Advantage managed care contracts to be the same. It remains to be seen whether this proposal becomes law.

Another important issue is quality of care. The Centers for Medicare and Medicaid Services recently started a website with several basic quality indicators for various common illnesses. Medicare also encourages the reporting of quality indicators by giving participating PPS providers higher payments. Since public quality data is new, it is too early to speculate on the possible impact on providers. Another quality indicator is accreditation by an outside credentialing organization. Of the 31 facilities in the study group, 14 were certified in 2002 by the Joint Commission on Accreditation of Healthcare Organizations. Only 13 received accreditation in 2003.

The topic of what hospitals charge for their services has also been newsworthy. Some have expressed concern that hospital charges negatively affect those without insurance and who are ineligible for discounts afforded to other payers. Again, public data has been made available on Wisconsin hospital charges. As with the quality data, the impact on providers of the availability of hospital charge information to consumers is unknown at this time. Some industry observers believe this information will lead to increased price competition among providers.

SUMMARY

More hospitals became eligible for CAH status because of the recent legislation which raised the maximum beds from 15 to 25. As a result, the number of Wisconsin CAH facilities has grown. In a recent preliminary study by MEDPAC, it was found the total margin of hospitals that switched to CAH status increased from a negative 1.2% in 1998 to 2.2% in 2003. The experience of Wisconsin CAH facilities is similar as total margins have increased from just over 0.0% to slightly over 4.5% for the same time period. Here are a number of observations :

1. The second tier of CAH converters (“Later” in our study) was relatively stronger before conversion in financial performance as measured by key financial ratios.
2. Total margins have improved. This ratio indicates that profitability has improved.
3. Overall financial strength as measured by the “Financial Strength Index” has improved for both study groups.
4. To date, no discernable trends in patient services provided by the study group have been detected.

Stronger financial performance will result in improved access to capital. Many CAH facilities still have aged facilities and must make major investments in plants and equipment, including technology. Some have already committed to this process. One of the goals of the CAH program was to improve financial performance and maintain access to quality local healthcare. The results of this study confirm that goal is being met. Medicare cost-based reimbursement will allow CAH facilities to continue to meet the healthcare needs in their communities.

OTHER RESOURCES

Here are several websites that have more information on CAHs:

Centers for Medicare & Medicaid Services Medicare Learning Network
<http://www.cms.hhs.gov/medlearn>

Centers for Medicare & Medicaid Services Rural Health Information
<http://www.cms.hhs.gov/providers/rh>

Centers for Medicare & Medicaid Services Critical Access Hospital Information
<http://www.cms.hhs.gov/providers/cah>

Centers for Medicare & Medicaid Services Federally Qualified Health Centers Information
<http://www.cms.hhs.gov/providers/fqhc>

Centers for Medicare & Medicaid Services American Indian and Alaska Native Information
<http://www.cms.hhs.gov/aian>

Administration on Aging
www.aoa.gov

Agency for Healthcare Research and Quality
www.ahrq.gov

Health Resources and Services Administration
www.hrsa.gov

Indian Health Service
www.ihs.gov

National Association of Community Health Centers
www.nachc.org

National Association of Rural Health Clinics
www.narhc.org

National Rural Health Association
www.nrharural.org

Rural Assistance Center
www.rac.org

United States Department of Agriculture
www.usda.gov

Rural Wisconsin Health Cooperative
www.rwhc.com

The Wisconsin Office of Rural Health
www.worh.org

Financial Ratios & Descriptions

RATIO	DESCRIPTION
Current Ratio	This ratio measures the hospital's ability to meet its current liabilities with its current assets (assets expected to be realized in cash during the fiscal year). A ratio of 1.0 or higher indicates that all current liabilities could be adequately covered by the hospital's existing current assets.
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.
Total Margin	This ratio evaluates the overall profitability of the hospital using both operating surplus (loss) and non-operating surplus (loss).
Return on Equity	Expression of net income relative to total equity.
Average Age of Plant	Age of plant is the average age of property, plant and equipment owned by the hospital.
Debt Financing Percent	Measures relationship of debts to assets.
Fixed Asset Turnover	Provides an indication of the efficiency with which the hospital uses its fixed assets to generate revenues.
Long-Term Debt to Equity	Measures hospital's burden of debt and the ability for additional borrowing.
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.