

# **The Financial Effects of Wisconsin Critical Access Hospital Conversion**

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# Table of Contents

<u>EXECUTIVE SUMMARY</u> .....	iii
<u>CRITICAL ACCESS HOSPITALS IN THE U.S.</u> .....	iv
<u>INTRODUCTION</u> .....	1
<u>SCOPE OF STUDY</u> .....	1
<u>REIMBURSEMENT CHANGES</u> .....	3
<u>FINANCIAL PERFORMANCE ANALYSIS</u> .....	3
<u>SUMMARY OF FINANCIAL IMPACT</u> .....	6
<u>ACCESS TO CAPITAL MARKETS</u> .....	10
<u>CHANGES IN SERVICES</u> .....	12
<u>QUALITY MEASUREMENTS</u> .....	18
<u>HEALTH INFORMATION TECHNOLOGY</u> .....	19
<u>LEGISLATIVE CHANGES</u> .....	19
<u>UNCOMPENSATED CARE</u> .....	20
<u>FLEX GRANTS</u> .....	20
<u>FUTURE OF CRITICAL ACCESS HOSPITALS</u> .....	21
<u>SUMMARY</u> .....	22
<u>OTHER RESOURCES</u> .....	23

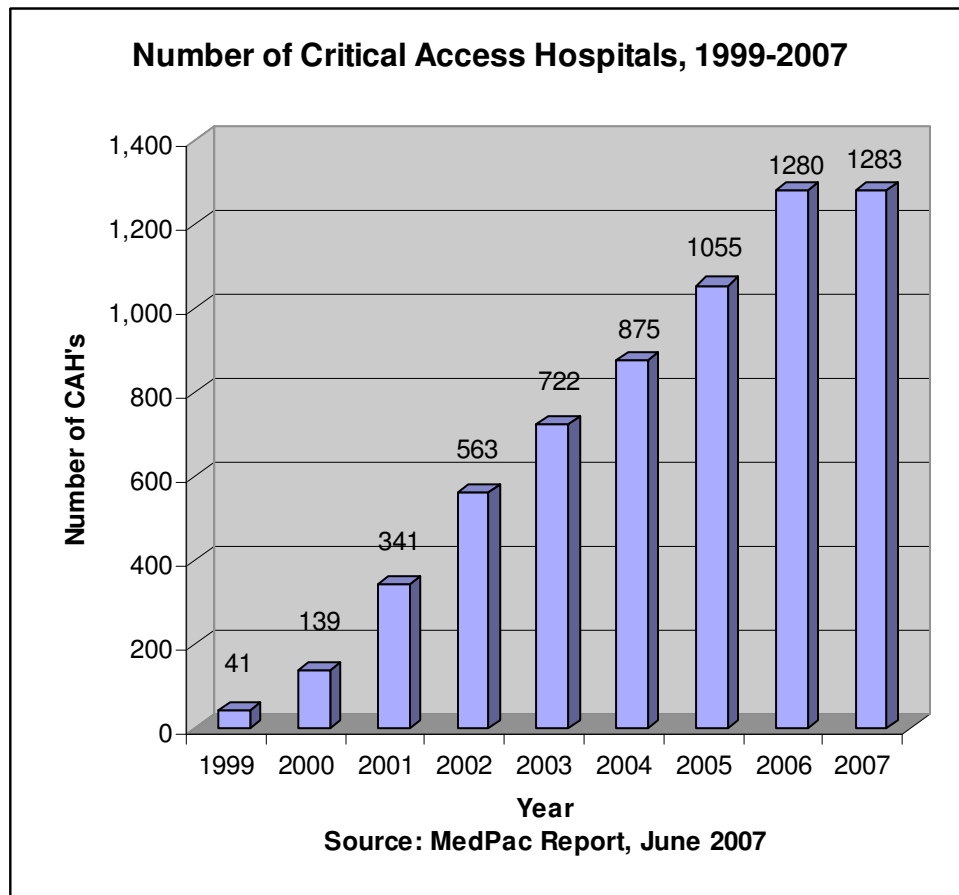
## EXECUTIVE SUMMARY

As of March 2007, there were 1,283 Critical Access Hospitals (CAHs) in the United States (see Chart 1). Wisconsin had 58 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 52 CAHs whose effective date is on or prior to February 1, 2005. This report updates previous studies completed in 2003 and 2005. Here are several observations from the analysis:

- The 17 facilities that converted prior to January 1, 2002, the "Phase 1" group, generally were smaller and not as strong financially as the 14 facilities converting on or after January 1, 2002, through January 1, 2004, known as the "Phase 2" group. The largest group (21 facilities) which we will call "Phase 3" facilities, converted to CAH status after January 1, 2004 and on or prior to February 1, 2005. Six facilities converted after February 1, 2005 and were not included in the study due to lack of financial data as critical access hospitals.
- All groups experienced improvements in several key financial ratios after conversion. Total margin, average age of plant, and the financial strength ratio all improved for all 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 improvement in the average age of plant ratio.
- An analysis of services provided by the study group indicates increases in some non-Medicare covered services and decreases in others. This indicates that hospital boards and management have decided to provide services based on factors other than CAH status, such as community benefit. See the "Changes in Services" section for further discussion of this issue.

One of the purposes of the 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. The CAH program has improved financial performance and as a result access to capital.

**Chart 1: Number of Critical Access Hospitals in the U.S., 1999-2007**



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. Currently, CAHs are paid their Medicare costs plus 1 percent for inpatient services, outpatient services (including laboratory and therapy services), and post-acute services in swing beds.

The number of CAHs nationally has grown steadily over the last eight years, from 41 in 1999 to 1,283 at the beginning of 2007.

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 would not meet the distance requirement. Therefore, the number of CAHs should remain fairly constant.

## INTRODUCTION

The purpose of this study is to report on the financial impact of designation of Wisconsin hospitals as CAHs. Similar reports were conducted in 2003 and 2005. 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 those 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 3% to just below 7% from 2001 to 2006.
- Phase 3 CAH converters were relatively stronger financially than the other groups before conversion as measured by key financial ratios used in this report.
- Operating Margins have improved.
- Overall strength as measured by the Financial Strength Index has improved for all study groups. Phase 1 facilities Financial Strength declined in 2005 and 2006.
- No discernable trends in patient services provided by the study group have been detected.

## SCOPE OF STUDY

As of August, 2007, Wisconsin had 58 CAH facilities. The first Wisconsin hospital received CAH designation on October 1, 1999. Table 1 shows when Wisconsin hospitals received CAH status and the number of facilities that are included in this update:

**Table 1: Wisconsin Certified CAH Facilities**

YEAR	Certified	Phase 1	Phase 2	Phase 3	Not included in study*	TOTAL
1999	2	2				2
2000	6	6				6
2001	9	9				9
2002	8		8			8
2003	6		6			6
2004	17			17		17
2005	9			4	5	9
2006 or after	1				1	1
Totals	58	17	14	21	6	58

\*-These facilities were not included in this study because of insufficient data as CAH.

There were 31 hospitals included in the 2005 study. For this study, we evaluated 17 hospitals in the Phase 1 group to determine how CAH status continues to affect their financial performance. Obviously, the Phase 1 group has the most history under CAH payment methodology. We also evaluated 14 facilities in the second Phase of facilities (Phase 2) which included those hospitals that received their CAH status in 2002 (8) or 2003 (6). In order to evaluate how the Phase 3 facilities are doing financially, we only used the 21 facilities that received their CAH status on or before February 1, 2005. Finally, we combined all 52 facilities to evaluate how their performance has been impacted by conversion to CAH status.

It must be stated that data from the 2005 study group may vary in the 2007 update. This is due to a number of reasons. Formulas used to accumulate data and calculate ratios for the 2003 and 2005 studies were improved and used for the 2007 study for consistency purposes. The assumptions and conclusions drawn from the previous study have not changed. 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. Some facilities are part of multi-hospital organizations which may have affected their balance sheet data. Some facilities may have made major changes in their organizations such as combining with a physician practice. 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 from 1999 to December 2006. Two caveats to the study must be stated. Phase 3 facilities have very little experience as critical access facilities so it is still very early to draw conclusions with certainty. The other issue is that even with 52 facilities, the group is relatively small. Financial performance and trends should not be applied to other groups. 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 hospitals audited financial statements. 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 October 1, 2002, through September 30, 2003, the information was included in the 2003 year. Medicare requires cost reports to be filed five months after the end of the provider's fiscal year. Most facilities critical access effective date occurred during their fiscal year. This required them to file short period cost reports. Therefore, 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 and updated in the spring of 2005.

## REIMBURSEMENT CHANGES

Under PPS, inpatient reimbursement is 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-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. For CAH cost reports beginning on or after January 1, 2004 there is a 1% add-on to allowable Medicare costs.

The Wisconsin Medical Assistance Program also reimburses CAHs based on costs. This is a significant improvement over the prospective system that the Wisconsin program uses for other hospitals.

## 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
<b>Current Ratio</b>	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.
<b>Days in Accounts Receivable (net)</b>	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.
<b>Days' Cash on Hand</b>	The number of days of expenses that the hospital can currently cover with its available cash.
<b>Total Margin</b>	This ratio evaluates the overall profitability of the hospital using both operating surplus (loss) and non-operating surplus (loss).
<b>Return on Equity</b>	Expression of net income relative to total equity.
<b>Average Age of Plant</b>	Age of plant is the average age of property, plant and equipment owned by the hospital.
<b>Debt Financing Percent</b>	Measures relationship of debts to assets.
<b>Fixed Asset Turnover</b>	Provides an indication of the efficiency with which the hospital uses its fixed assets to generate revenues.
<b>Long-Term Debt to Equity</b>	Measures hospital's burden of debt and the ability for additional borrowing.
<b>Deduction Ratio</b>	The deduction percentage measures the proportion of total patient charges that are given up as discounts and allowances.
<b>Financial Strength Index</b>	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**

<b>RATIO</b>	<b>CALCULATION</b>
<b>Current Ratio</b>	Current assets/Current liabilities
<b>Days in Accounts Receivable (net)</b>	Net accounts receivable/Net patient revenue per day
<b>Days' Cash on Hand</b>	Cash/(Operating expenses less depreciation/365)
<b>Total Margin</b>	Excess of revenue over expenses/Total revenue
<b>Return on Equity</b>	Excess of revenues over expenses/Net Assets
<b>Average Age of Plant</b>	Accumulated depreciation/Depreciation expense
<b>Debt Financing Percent</b>	Total liabilities/Total assets
<b>Fixed Asset Turnover</b>	Total revenue/Net plant, property and equipment
<b>Long-Term Debt to Equity</b>	Total long-term debt/Net assets
<b>Deduction Ratio</b>	Total patient revenue-net patient revenue/Total patient revenue
<b>Financial Strength Index</b>	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**

<b>Dimensions of Financial Strength</b>	<b>Measured by</b>
<b>Profits</b>	Total margin
<b>Liquidity</b>	Days' cash on hand
<b>Debt expense</b>	Debt financing %
<b>Age of physical facilities</b>	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:

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

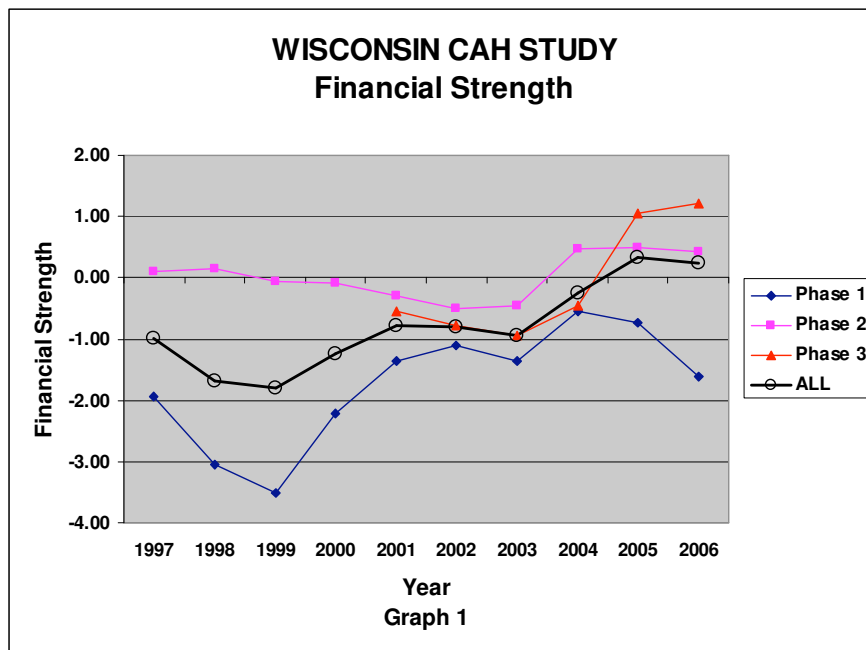
Organizations that have high margins, lots of cash, little debt, and new facilities are in better financial condition and have higher FSI. On the other hand, entities with losses, little cash, lots of debt, and old physical facilities have lower ratios. Table 6 is a suggested guide to rate FSI.

**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.<sup>1</sup>

Prior studies showed a slight improvement in the Financial Strength ratio. The graph below continues to show improvement in 2004 and 2005:

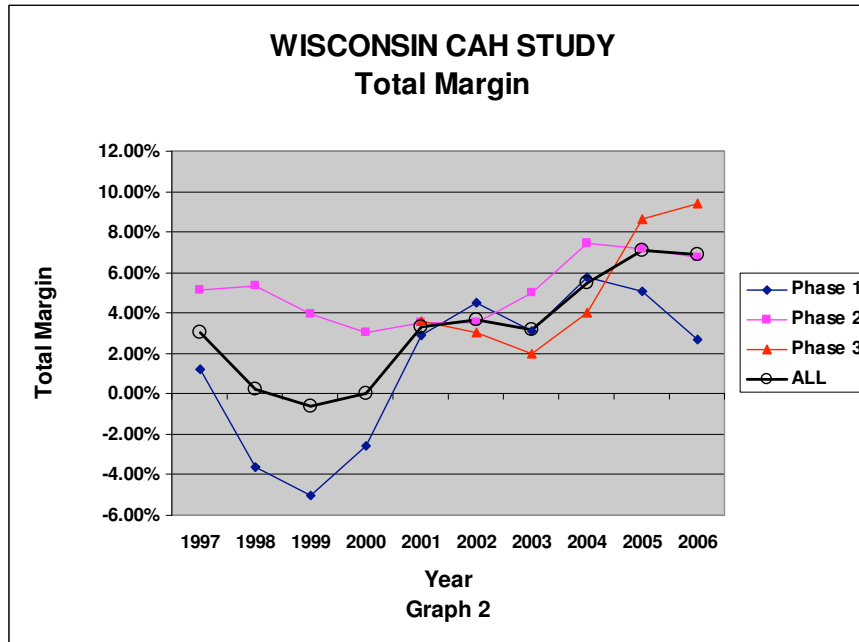


The graph shows that Phase 1 facilities generally had lower Financial Strength ratios than the other groups. When all Groups are combined, the 2006 Financial Strength ratio is .25. Per the rating guide in Table 6, this financial strength rating puts the study group in the lower end of “Good” range of financial health.

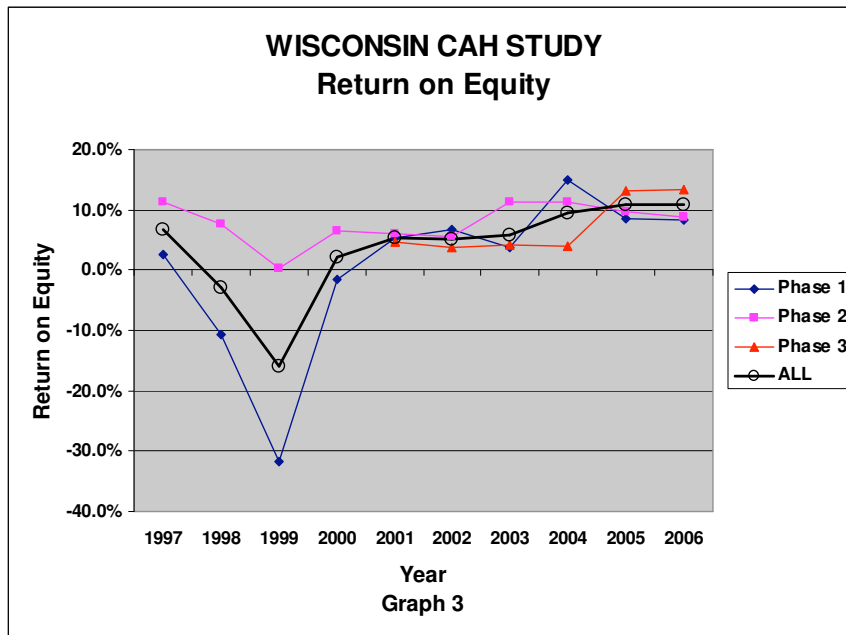
<sup>1</sup> SOURCE: “The Financial Strength Index: A Measure of a Firm’s Overall Financial Health,” by William O. Cleverley, Ph.D., President, Cleverley & Associates, and Andrew E. Cameron, Ph.D., MBA, Assistant Professor, Ohio State University. Published in the January 2003 issue of HFMA’s newsletter,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

## SUMMARY OF FINANCIAL IMPACT

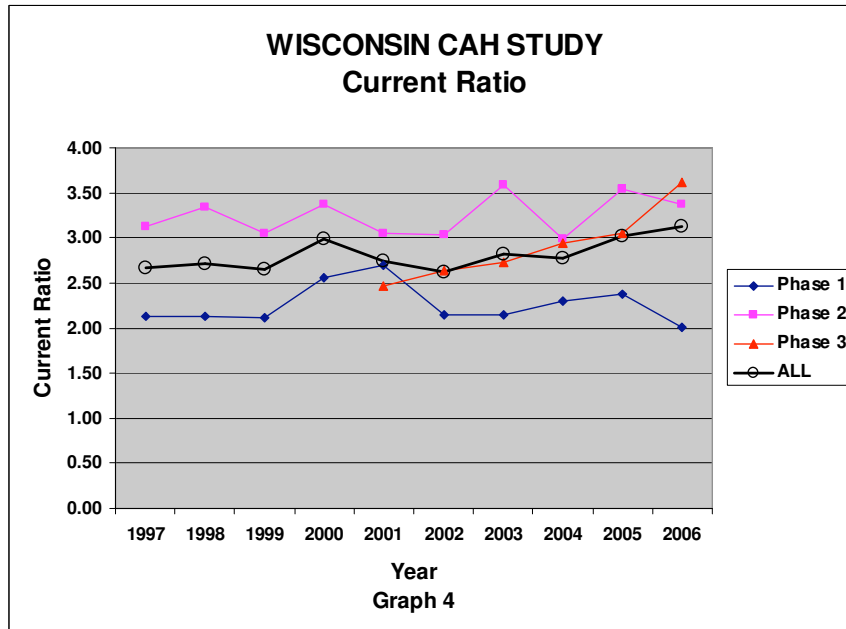
Both the 2003 and 2005 studies showed general improvement in the financial performance of facilities that converted to CAH status. The 2007 updated analysis of various financial ratios indicates continued improvement in some ratios while others show a leveling off or slight decline. Wisconsin CAHs have higher Total Margin, Return on Equity, and Deduction Ratio for 2004 than recent studies of national averages indicate. Average Age of Plant and Days in Accounts Receivable (net) are about the same as the national average.



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 all Phase groups have improved in this key ratio since conversion. Phase 1 Total Margin declined in 2005 and 2006. It must be pointed out that many other factors influence hospital financial performance besides Medicare payment. Other causes may be contributing to the decline in Total Margin for this group of facilities. Phase 3 facilities have shown a dramatic increase in Total Margin in 2005 and 2006. Although conversion probably contributed to this improvement, improvements in other areas may also be a factor. Total Margin for All facilities for 2005 and 2006 was about 7%.

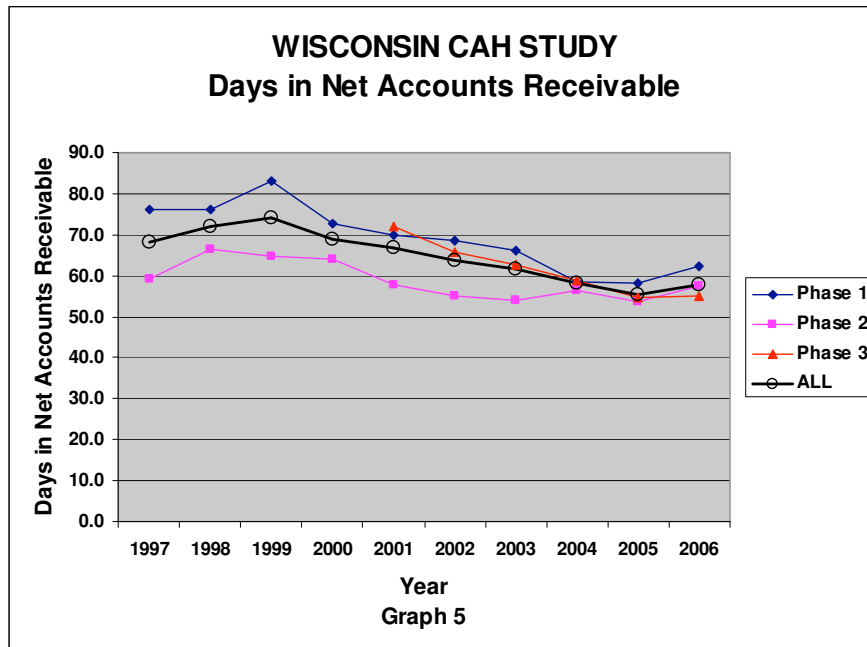


Another financial ratio related closely to Total Margin is Return on Equity. This ratio is calculated by dividing Net Income by Equity. Equity is also referred to as “Net Assets” which is Total Assets minus Liabilities. This graph shows relatively flat Returns on Equity for Phase 2 from 2003 to 2006. Phase 3 facilities increased from about 4% in 2004 to about 13% in 2005 and 2006. This group affected the Return on Equity increase in 2005 and 2006 for all facilities.

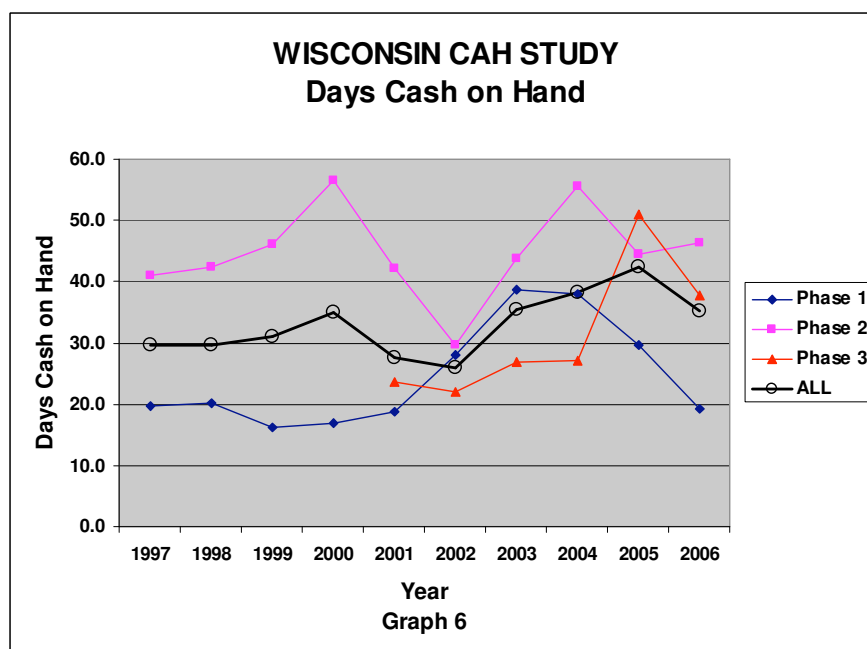


The Current Ratio indicates the ratio of current assets to current liabilities. Current assets are those assets of a company that are reasonably expected to be realized in cash, or sold, or consumed during the normal operating cycle of the business (usually one year). Such assets include cash, accounts receivable due usually within one year, short-term investments, inventories, and prepaid

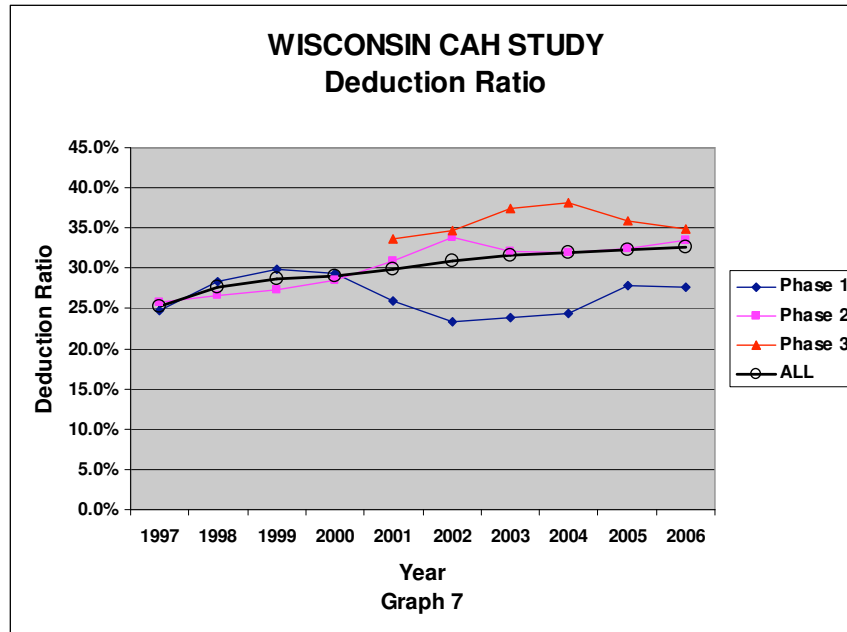
expenses. Current liabilities are liabilities to be paid within one year of the balance sheet date. A ratio greater than 1.0 indicates all current liabilities are covered by existing current assets.



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. The slight increase in 2006 may indicate the impact on this ratio of an industry-wide shift to more self-pay accounts. This ratio is approximately the same as the national average for hospitals.



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 chart indicates a decline in day's cash on hand for Phase 1 since 2003. The graph also shows a slight drop for "All" facilities in 2006. As mentioned in the Days in Accounts Receivable discussion, days in accounts receivable increased. This may have had a negative impact on Days' Cash on Hand. This ratio has been subject to considerable fluctuation. One reason for this may be the definition of cash. Some data may include short-term investments and board-designated funds as cash which results in higher days cash on hand. For purposes of this study, only "Cash" or "Cash and Cash Equivalents," as reported the by facilities, was used as the numerator.



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 "All" facilities, the graph reflects a growing gap between hospital "gross" charges and the "net" charges for services provided. Generally, the deduction ratio actually declines for a year or two after conversion but increases in later years. 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). Since the conversion to CAH status reduced discounts to the Medicare and Medicaid programs, it can be concluded that all-other payers are now receiving higher discounts.

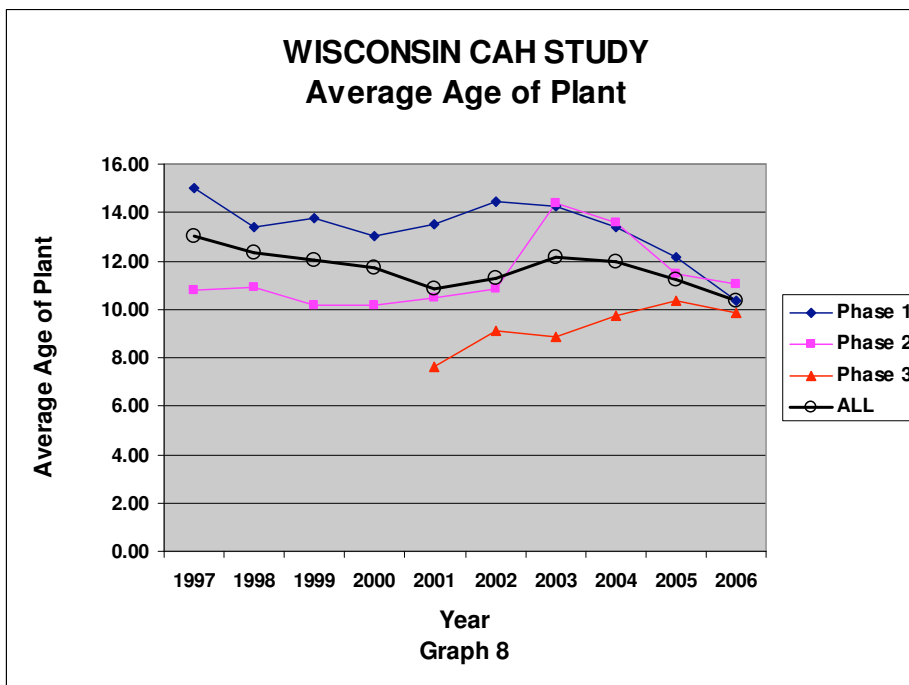
**Table 7: Medicare Utilization (Based on Patient Days)**

Year	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Phase 1	78.1%	81.6%	80.2%	79.3%	79.1%	80.4%	82.4%	82.2%	82.0%	82.5%
Phase 2	74.6%	73.1%	72.6%	73.6%	71.4%	73.5%	74.5%	73.5%	72.5%	73.2%
Phase 3					81.0%	76.7%	76.0%	78.5%	80.5%	78.0%
All	76.2%	77.2%	76.2%	76.3%	77.3%	76.8%	77.4%	78.2%	78.7%	76.4%

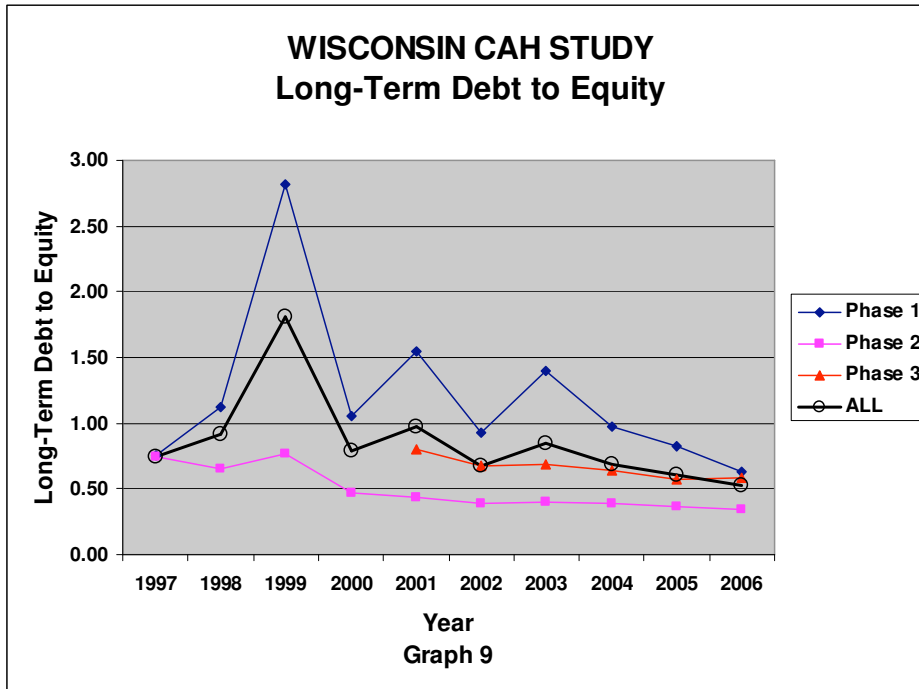
## ACCESS TO CAPITAL MARKETS

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.

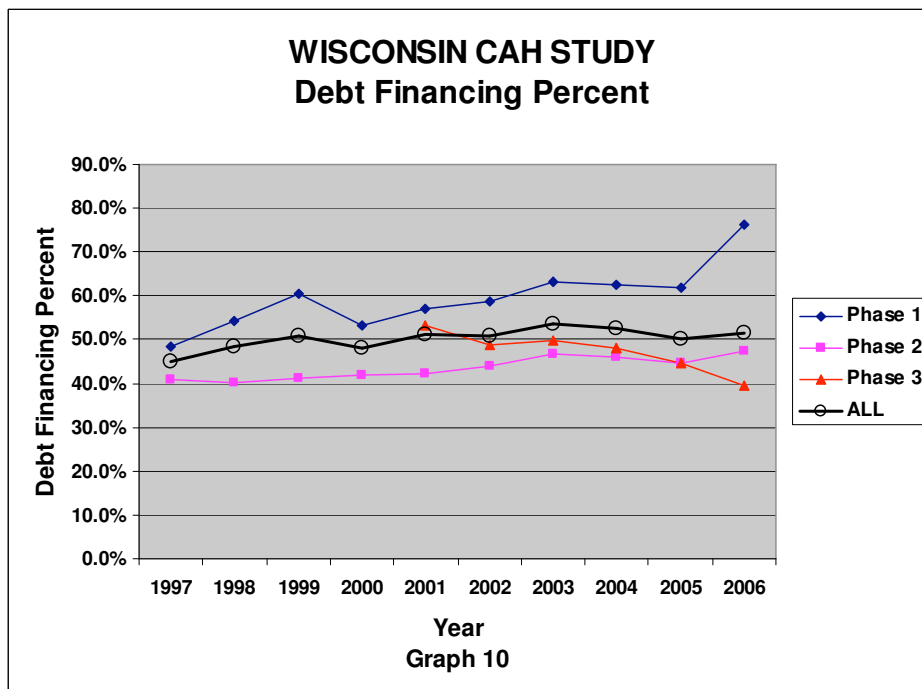


Average Age of Plant is calculated by dividing Accumulated Depreciation by Depreciation Expense. Lower ratios are favorable as are decreasing trends. The chart shows a decline in average age of plant ratios for "All" facilities for 2005 and 2006. This would indicate that capital improvements have been 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 Average Age of Plant has declined to slightly over 10 for 2006.

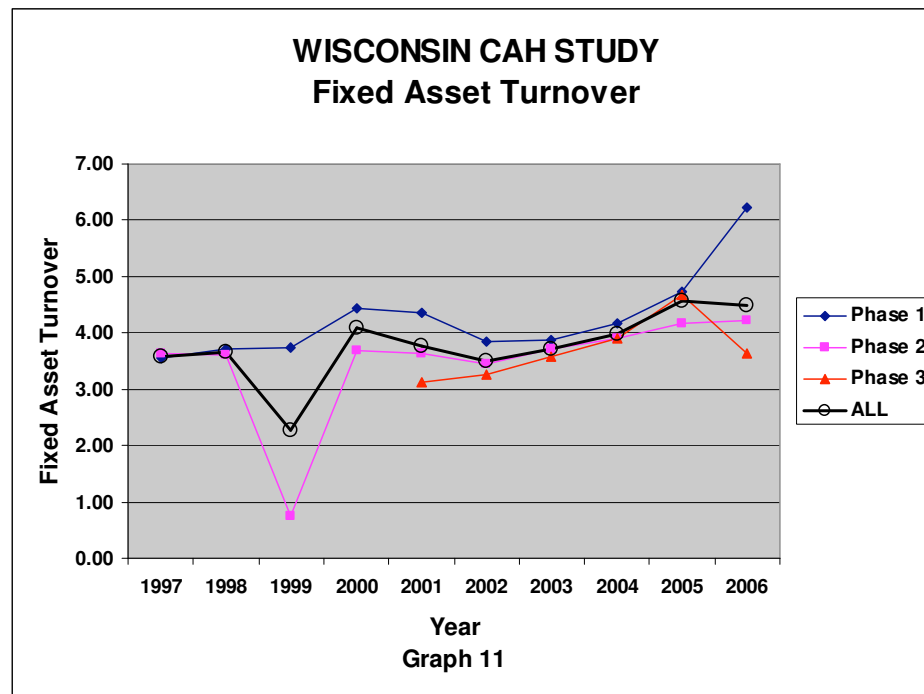


Long Term Debt to Equity ratio is long term debt divided by “Equity” also referred to “Net Assets”. This ratio measures the entities’ burden of long-term debt and the ability to borrow additional funds. Low values are favorable.

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 Debt Financing Percent ratio measures the relationship of debts to assets. It is calculated by dividing total liabilities by total assets. Low ratios are favorable. The All group showed a slight decline in this ratio in 2004 and 2005. The ratio increased slightly in 2006 to just over 51%.



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. Although "All" facilities showed increases in this ratio in 2003, 2004, and 2005, the Fixed Asset Turnover ratio declined slightly in 2006. This may be due to increased investment in buildings and equipment.

## CHANGES IN SERVICES

As mentioned previously, CAH facilities are reimbursed the cost they incur for 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. Medicare does not pay for all services and Medicare's 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 very low. Another example of how financial considerations may effect which services CAHs provide are Home Health Agencies and Skilled Nursing Facilities (SNF). Although these services are covered by Medicare, they have separate payment systems. For example, SNF Medicare payment system is based on prospective Resource Utilization Groups or "RUGS". Therefore, under a CAH Medicare cost report, all direct and indirect cost are allocated to the SNF and excluded from hospital costs. Fixed costs will be incurred if the service is provided or not. CAHs may determine that the allocation of cost to either 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. CAHs decisions on which 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. One factor that determines the impact on payments is Medicare utilization. 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 can be a factor for CAH facilities in deciding which services to provide. The table shows an increase in the number of CAHs providing expensive radiology services. CT Scanner services increased from 41 in 1997 to 50 in 2005 and Magnetic Resonance Imaging(MRI) services increased from 8 in 1997 to 19 in 2005.

Table 8, below and on the following pages, shows a number of common patient healthcare services. The table indicates what services are provided at CAH facilities for the years 1999 through 2005.

**Table 8**

<b>Number of Facilities Reporting SERVICE</b>	<b>47 1999</b>	<b>48 2000</b>	<b>48 2001</b>	<b>52 2002</b>	<b>52 2003</b>	<b>52 2004</b>	<b>52 2005</b>
<b>ADULT MEDICAL/SURGICAL, ACUTE</b>							
Phase 1	16	17	17	17	17	17	17
Phase 2	13	13	13	14	14	14	14
Phase 3	18	18	18	21	21	21	21
All	47	48	48	52	52	52	52
<b>ORTHOPEDIC</b>							
Phase 1	14	14	15	14	15	14	13
Phase 2	10	10	10	11	10	8	9
Phase 3	16	16	17	20	20	19	19
All	40	40	42	45	45	41	41
<b>REHABILITATION AND PHYSICAL MEDICINE</b>							
Phase 1	9	7	7	7	7	6	7
Phase 2	6	7	7	9	9	8	8
Phase 3	10	10	10	12	13	14	12
All	25	24	24	28	29	28	27
<b>HOSPICE</b>							
Phase 1	8	9	7	6	6	7	7
Phase 2	8	6	7	8	8	7	7
Phase 3	10	10	10	11	13	14	14
All	26	25	24	25	27	28	28
<b>PEDIATRICS</b>							
Phase 1	15	14	14	15	16	15	15
Phase 2	13	13	13	14	13	11	11
Phase 3	16	16	16	19	19	18	18
All	44	43	43	48	48	44	44
<b>OBSTETRICS</b>							
Phase 1	9	8	8	8	7	7	7
Phase 2	12	12	12	11	11	10	10
Phase 3	18	18	18	20	20	19	19
All	39	38	38	39	38	36	36

Number of Facilities Reporting SERVICE	47 1999	48 2000	48 2001	52 2002	52 2003	52 2004	52 2005
<b>PSYCHIATRIC</b>							
Phase 1	1	1	1	1	1	0	0
Phase 2	0	0	0	0	1	0	0
Phase 3	3	3	3	4	4	3	2
All	4	4	4	5	6	3	2
<b>ALCOHOLISM/CHEMICAL DEPENDENCY</b>							
Phase 1	4	5	5	4	5	2	1
Phase 2	1	2	2	2	2	1	1
Phase 3	4	5	5	6	5	4	3
All	32	31	31	34	32	31	31
<b>CARDIAC INTENSIVE CARE</b>							
Phase 1	5	5	5	5	5	4	4
Phase 2	9	8	7	8	6	5	5
Phase 3	15	14	14	17	15	15	12
All	29	27	26	30	26	24	21
<b>PEDIATRIC INTENSIVE CARE</b>							
Phase 1	2	2	2	2	2	2	2
Phase 2	2	2	2	1	1	1	1
Phase 3	6	6	6	8	7	6	4
All	10	10	10	11	10	9	7
<b>MIXED INTENSIVE CARE</b>							
Phase 1	6	7	5	6	5	4	4
Phase 2	8	8	7	8	7	5	5
Phase 3	12	12	12	14	13	9	9
All	26	27	24	28	25	18	18
<b>STEP-DOWN</b>							
Phase 1	4	4	4	3	2	3	2
Phase 2	4	5	5	5	3	3	3
Phase 3	8	7	7	8	7	7	6
All	16	16	16	16	12	13	11
<b>MEDICARE CERTIFIED SWING UNITS</b>							
Phase 1	16	17	17	17	17	16	16
Phase 2	13	13	12	13	12	14	14
Phase 3	17	17	17	19	18	19	20
All	46	47	46	49	47	49	50
<b>NEWBORN NURSERY</b>							
Phase 1	9	8	8	8	7	7	7
Phase 2	12	12	12	11	10	10	11
Phase 3	18	18	18	20	20	20	20
All	39	38	38	39	37	37	38
<b>LABOR, DELIVERY, POSTPARTUM ROOM</b>							
Phase 1	9	8	9	8	7	7	7
Phase 2	12	12	12	11	11	11	11
Phase 3	18	18	18	20	18	18	18
All	39	38	39	39	36	36	36
<b>CARDIAC REHABILITATION PROGRAM</b>							
Phase 1	14	15	15	15	14	14	15
Phase 2	12	12	12	13	13	13	13
Phase 3	13	14	14	17	18	17	18
All	39	41	41	45	45	44	46

Number of Facilities Reporting SERVICE	47 1999	48 2000	48 2001	52 2002	52 2003	52 2004	52 2005
<b>HEMODIALYSIS</b>							
Phase 1	1	1	1	1	1	2	2
Phase 2	1	1	1	1	1	1	1
Phase 3	1	1	1	1	0	0	0
All	3	3	3	3	2	3	3
<b>EMERGENCY DEPARTMENT (GENERAL)</b>							
Phase 1	16	17	17	17	17	17	17
Phase 2	13	13	13	14	14	14	14
Phase 3	18	18	18	21	21	21	21
All	47	48	48	52	52	52	52
<b>TRAUMA CENTER</b>							
Phase 1	5	5	5	6	6	8	10
Phase 2	3	3	3	3	3	2	5
Phase 3	5	7	7	8	8	9	9
All	13	15	15	17	17	19	24
<b>URGENT CARE CENTER</b>							
Phase 1	6	8	8	8	8	8	9
Phase 2	10	11	10	9	9	10	10
Phase 3	9	9	9	12	11	12	11
All	25	28	27	29	28	30	30
<b>FITNESS CENTER</b>							
Phase 1	4	5	5	5	5	3	4
Phase 2	4	3	3	3	2	3	3
Phase 3	6	8	7	10	11	9	11
All	14	16	15	18	18	15	18
<b>MEALS ON WHEELS</b>							
Phase 1	4	6	6	6	7	6	6
Phase 2	6	7	7	7	7	7	7
Phase 3	4	4	4	6	6	6	6
All	14	17	17	19	20	19	19
<b>NUTRITION PROGRAMS</b>							
Phase 1	13	15	15	15	16	16	15
Phase 2	10	11	11	12	10	11	11
Phase 3	10	12	12	14	15	16	16
All	33	38	38	41	41	43	42
<b>GERATRIC ACUTE CARE UNIT</b>							
Phase 1	5	5	5	4	4	4	3
Phase 2	1	1	1	1	1	2	2
Phase 3	2	2	2	2	3	2	2
All	8	8	8	7	8	8	7
<b>RESPIRE CARE</b>							
Phase 1	14	15	14	14	14	14	14
Phase 2	8	9	8	9	9	9	9
Phase 3	11	11	11	14	16	15	16
All	33	35	33	37	39	38	39
<b>COMMUNITY HEALTH PROMOTION</b>							
Phase 1	15	15	15	15	15	15	15
Phase 2	13	13	13	14	13	12	12
Phase 3	18	18	18	21	21	21	21
All	46	46	46	50	49	48	48

<b>Number of Facilities Reporting SERVICE</b>	<b>47</b>	<b>48</b>	<b>48</b>	<b>52</b>	<b>52</b>	<b>52</b>	<b>52</b>
	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>PATIENT EDUCATION</b>							
Phase 1	16	16	16	16	16	16	16
Phase 2	12	12	12	13	12	13	13
Phase 3	18	18	18	21	21	21	21
All	46	46	46	50	49	50	50
<b>DIAGNOSTIC MAMMOGRAPHY</b>							
Phase 1	14	15	15	16	15	14	14
Phase 2	13	12	12	13	12	13	13
Phase 3	15	16	16	20	20	20	19
All	42	43	43	49	47	47	46
<b>MAMMOGRAPHY SCREENING</b>							
Phase 1	14	16	16	16	15	15	15
Phase 2	13	12	12	13	13	13	13
Phase 3	15	16	16	20	20	20	19
All	42	44	44	49	48	48	47
<b>OCCUPATIONAL HEALTH SERVICES</b>							
Phase 1	10	10	10	11	12	12	13
Phase 2	11	11	11	12	12	12	12
Phase 3	14	14	14	18	17	17	15
All	35	35	35	41	41	41	40
<b>AUDIOLOGY</b>							
Phase 1	9	8	8	6	6	7	6
Phase 2	6	5	5	5	5	5	5
Phase 3	5	5	5	6	4	3	3
All	20	18	18	17	15	15	14
<b>OCCUPATIONAL THERAPY</b>							
Phase 1	13	14	14	15	15	15	15
Phase 2	10	10	10	11	12	12	12
Phase 3	18	18	18	20	19	20	20
All	41	42	42	46	46	47	47
<b>PHYSICAL THERAPY</b>							
Phase 1	15	17	17	17	17	17	17
Phase 2	13	13	13	14	14	14	14
Phase 3	18	18	18	21	20	21	21
All	46	48	48	52	51	52	52
<b>RECREATIONAL THERAPY</b>							
Phase 1	7	5	5	7	7	10	6
Phase 2	5	5	5	5	6	6	5
Phase 3	2	2	2	4	5	5	4
All	14	12	12	16	18	21	15
<b>REHABILITATION INPATIENT SERVICES</b>							
Phase 1	10	11	11	11	14	13	14
Phase 2	8	9	9	10	11	11	12
Phase 3	13	11	11	13	15	12	14
All	31	31	31	34	40	36	40
<b>REHABILITATION OUTPATIENT SERVICES</b>							
Phase 1	13	14	14	15	15	15	14
Phase 2	10	11	11	12	11	12	13
Phase 3	14	14	14	17	17	16	17
All	37	39	39	44	43	43	44

Number of Facilities Reporting SERVICE	47 1999	48 2000	48 2001	52 2002	52 2003	52 2004	52 2005
<b>RESPIRATORY THERAPY</b>							
Phase 1	15	16	16	15	15	14	14
Phase 2	10	10	10	11	13	11	12
Phase 3	18	18	18	21	21	21	21
All	43	44	44	47	49	46	47
<b>SPEECH PATHOLOGY/THERAPY</b>							
Phase 1	9	9	10	10	10	9	9
Phase 2	7	6	6	7	10	11	11
Phase 3	11	11	10	12	11	11	13
All	27	26	26	29	31	31	33
<b>ONCOLOGY SERVICES</b>							
Phase 1	3	3	3	4	7	6	5
Phase 2	5	4	5	6	6	6	6
Phase 3	11	12	12	15	14	14	13
All	19	19	20	25	27	26	24
<b>CT SCANNER</b>							
Phase 1	12	13	15	16	16	16	16
Phase 2	12	13	13	14	14	14	14
Phase 3	17	17	18	21	21	21	20
All	41	43	46	51	51	51	50
<b>DIAGNOSTIC RADIOISOTOPE FACILITY</b>							
Phase 1	2	3	2	1	1	1	2
Phase 2	6	6	7	6	7	7	6
Phase 3	3	4	3	3	4	6	5
All	11	13	12	10	12	14	13
<b>MAGNETIC RESONANCE IMAGING</b>							
Phase 1	2	3	3	3	3	3	5
Phase 2	2	3	3	2	3	4	3
Phase 3	4	4	4	9	12	8	11
All	8	10	10	14	18	15	19
<b>ULTRASOUND</b>							
Phase 1	9	11	11	11	10	10	11
Phase 2	8	9	9	10	10	11	11
Phase 3	14	14	14	17	19	18	17
All	31	34	34	38	39	39	39
<b>SOCIAL WORK SERVICES</b>							
Phase 1	13	14	14	13	14	15	15
Phase 2	12	12	12	13	13	12	11
Phase 3	17	17	17	20	20	20	19
All	42	43	43	46	47	47	45
<b>SPORTS MEDICINE CLINIC/SERVICES</b>							
Phase 1	7	8	8	8	8	9	8
Phase 2	11	10	10	11	9	10	9
Phase 3	10	11	11	14	14	11	14
All	28	29	29	33	31	30	31
<b>SURGERY, AMBULATORY OR OUTPATIENT (DAY SURGERY)</b>							
Phase 1	15	16	16	16	16	16	16
Phase 2	13	13	13	14	14	14	14
Phase 3	18	18	18	21	21	21	21
All	46	47	47	51	51	51	51

Source: State of Wisconsin Annual Survey of Hospitals  
Service only counted if provided in or by the hospital

In addition to Table 8 above, several service and management-related criteria are provided in Table 9:

**Table 9**

<b>Number of Facilities Reporting</b>	<b>52</b>	<b>52</b>	<b>52</b>	<b>52</b>
<b>SERVICE/OTHER</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>HOSPITAL OWNS AND OPERATES SNF</b>				
Phase 1	9	9	9	9
Phase 2	6	6	6	5
Phase 3	5	5	5	4
All	20	20	20	18
<b>HOSPITAL IS CONTRACT MANAGED</b>				
Phase 1	5	5	5	5
Phase 2	5	5	5	5
Phase 3	6	5	5	5
All	16	15	15	15
<b>PART OF HEALTH CARE SYSTEM</b>				
Phase 1	11	11	12	12
Phase 2	4	4	4	4
Phase 3	5	5	5	7
All	20	20	21	23
<b>ACCREDITATION STATUS</b>				
Phase 1	8	7	6	7
Phase 2	9	9	9	8
Phase 3	17	17	15	14
All	34	33	30	29
Source: State of Wisconsin Annual Survey of Hospitals				

Table 9 shows two additional facilities in Phase 3 are part of health care systems. Phase 3 hospitals also show a reduction in Accreditation from 17 in 2002 to only 14 in 2005. One less facility in both Phase 2 and Phase 3 owns and operates a Skilled Nursing Facility (SNF).

## QUALITY MEASUREMENTS

As consumers become educated about healthcare services, more information regarding quality of care is becoming publicly available. The United States Department of Health and Human Services has a website named Hospital Compare which reports quality data. This information is sometimes difficult to use for critical access hospitals because of the low-volume of cases. Prospective Payment System (PPS) hospitals are eligible for additional payment from CMS if they report quality data. So far, no financial incentives have been provided by CMS to critical access hospitals to participate in quality measurement systems. Even without these incentives, about 75% of Wisconsin CAHs participate in Hospital Compare. Nationally, about 53% of CAHs participate. Also, all of Wisconsin's CAHs participate in the Wisconsin Hospital Association's CheckPoint program, which makes quality data available to the public through a website.

## **HEALTH INFORMATION TECHNOLOGY**

Many Critical Access Hospitals 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. A May 2006 study titled “The Current Status of Health Information Technology Use in CAHs” by the University of Minnesota, University of North Carolina and the University of Southern Maine indicates “adoption of HIT is a priority for CAHs”. Investment in HIT has the potential to improve quality while controlling costs.

The Rural Wisconsin Health Cooperative (RWHC), a group of over 30 small, rural hospitals in Wisconsin, in partnership with the Wisconsin Office of Rural Health, was recently 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.

## **LEGISLATIVE CHANGES**

As previously mentioned, in order to be designated as a CAH, a facility must be located in a rural area and must meet a distance requirement (at least 35 miles or in the case of mountainous terrain or in areas with only secondary roads, 15 miles from the nearest hospital or other CAH). Prior to January 1, 2006, states were permitted to waive the CAH distance requirement by certifying that a CAH was a “necessary provider”. On December 8, 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) became law. Effective January 1, 2006 the MMA ended the authority of states to waive the location requirement by certifying CAHs as necessary providers.

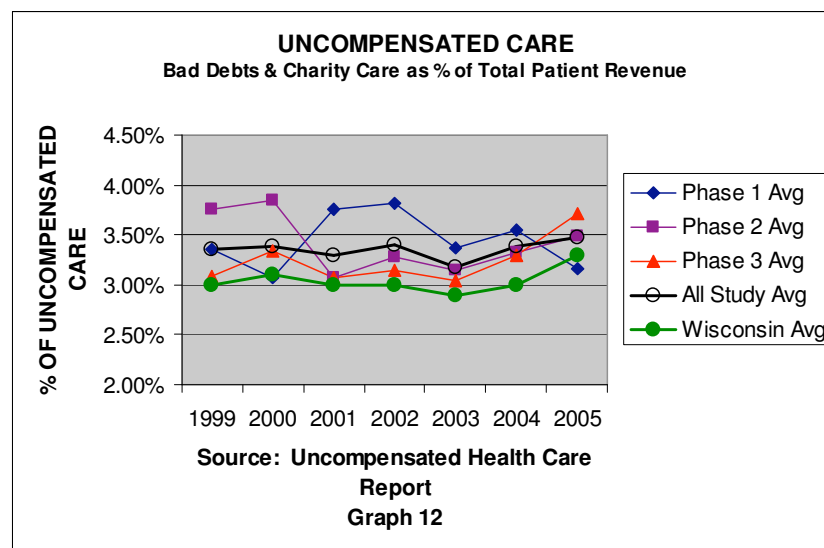
Additional changes, either through legislation or CMS rule making, could impact the ability of CAHs to continue to provide essential services in the communities they serve. Proposed rules that would make it difficult for a CAH to build a replacement facility, or would limit Medicare services that are eligible for cost-based reimbursement to those offered in the hospital building itself, could have a detrimental effect on the future of CAHs. The success of the CAH program could be jeopardized by additional constraints on the ability of CAHs to operate efficiently and effectively in their communities.

## Medicare Advantage

As stated in the previous study, Medicare Advantage (MA) brings the most significant changes to Medicare since its inception. The program creates opportunities for increased access and services to Medicare beneficiaries, but may create major problems for CAH providers. A July 2007 CMS report on MA penetration indicates that over 20% of Wisconsin beneficiaries are members of a private plan. As this trend continues, problems in identification of MA patients, billing, and reimbursement grow. Private Fee-for-Service (PFFS) plans are a particular problem for rural facilities. Rural facilities also lack negotiating power and therefore are at a disadvantage when negotiating a contract with MA plans. CAHs are experiencing changes in MA utilization of services, especially swing-beds. Because of the retrospective nature of CAH Medicare payment, some MA plans struggle to pay providers correctly. Delays in payments due to new billing and reporting requirements are also common. As MA plans continue to grow, CAHs payment gains under traditional Medicare are at risk.

## UNCOMPENSATED CARE

The issue of uncompensated care continues to be an issue for healthcare providers. Graph 12 shows Wisconsin CAHs continue to provide higher than average levels of uncompensated care compared to the average for Wisconsin hospitals. The information for this graph was taken from the Uncompensated Care Survey report based on information provided by Wisconsin hospitals.



## 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 was made available to the Health Resources & Services Administration for administering these grants.

## **FUTURE OF CRITICAL ACCESS HOSPITALS**

Most facilities who qualify to become critical access hospitals have already converted. Therefore, it is unlikely the 1,300 CAHs are going to increase substantially. Changes in CAH eligibility rules may not happen in the foreseeable future due to federal budget shortfalls. A major challenge to the gains CAHs have experienced under traditional Medicare is the growth of Medicare Advantage plans. As reported in the 2005 report, 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. This legislation remains a proposal as of this study. Another challenge to some CAHs will be the potential for CMS's proposed changes to the necessary provider rules. If this proposal is included in the final rule which will be published later this year, CAHs will need to carefully consider the impact on their status of any future relocation decisions.

The topic of what hospitals charge for their services continues to be newsworthy. Some facilities have responded by sharing pricing information and offering discounts to uninsured and under-insured. Public data has been made available on Wisconsin hospital charges by the Wisconsin Hospital Association Information Center through its PricePoint website. As mentioned in the 2005 study, the impact on providers of the availability of hospital charge information to consumers is still unknown at this time. Publicly available charge information may lead to increased price competition.

Quality improvement (QI) and measurement also remain high on the list of CAHs concerns. Even though financial incentives such as have been provided to PPS facilities have not been made available to CAHs, the availability of public reporting may be required for CAHs to compete. Private payers will also drive the participation of CAHs to report quality data.

Many challenges continue to face Wisconsin Critical Access Hospitals. Health information technology will be a major challenge. The proposed rule change regarding necessary provider changes in the 2008 outpatient prospective payment system may negatively impact some CAHs. The continued growth of Medicare Advantage plans potentially could negate the gains seen under traditional Medicare. Future studies will provide the answer to these questions and more.

## SUMMARY

As in 2003 and 2005, this 2007 update indicates CAH status generally has improved the financial position of Wisconsin facilities. The Average Age of Plant ratio has improved as has the Financial Strength Index ratio. Stronger financial performance has resulted in access to capital and major investments in plant and equipment. Many CAH facilities, like PPS reimbursed organizations, are investing heavily in health information technology. Financial performance of all three Phases in the study improved the most soon after conversion. The financial performance of many facilities leveled off after this initial period. Some additional observations are as follows:

1. Phase one facilities continue to have the most challenges in maintaining financial viability
2. Investment in facilities, equipment and technology continues strong
3. No discernable trends in the nature of patient services provided have been detected

Because of the high Medicare utilization of rural Wisconsin hospitals, increased payment for Medicare beneficiaries has a large impact on overall financial performance. However, many other factors contribute as well. Some of these factors are:

1. Medical Staff
2. Management and Board of Directors
3. General financial strength of surrounding communities and service area
4. Hospital staff
5. Competition
6. Quality of care
7. Payers

Many factors contribute to the financial condition of the organizations in this study. 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. As we have seen in this study, Medicare accounts for over 70% of patient days in most facilities. This leaves a relatively small number of payers to provide the income needed for costs not covered by Medicare such as bad debts, capital needs in excess of depreciation, and working capital.

Improved financial performance, and a level of financial stability, has allowed CAHs to continue to provide essential services within their communities. One of the goals of the CAH program was to improve financial performance and maintain access to quality local healthcare. For the period covered by this study, it appears that this goal is being met.

## OTHER RESOURCES

Here are several websites that have more information on CAHs:

Administration on Aging [www.aoa.gov](http://www.aoa.gov)

Agency for Healthcare Research and Quality [www.ahrq.gov](http://www.ahrq.gov)

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

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](http://www.hrsa.gov)

Indian Health Service [www.ihs.gov](http://www.ihs.gov)

National Association of Community Health Centers [www.nachc.org](http://www.nachc.org)

National Rural Health Association [www.nrharural.org](http://www.nrharural.org)

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

Rural Wisconsin Health Cooperative [www.rwhc.com](http://www.rwhc.com)

United States Department of Agriculture [www.usda.gov](http://www.usda.gov)

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

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

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

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

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