Legislative Fiscal Bureau
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March 16, 2010

TO: Members
Joint Committee on Finance

FROM: Bob Lang, Director

SUBJECT: Assembly Bill 770 and Senate Bill 553: Critical Access Hospitals -- Assessment and MA Rate Increase

Assembly Bill 770 and Senate Bill 553 are identical bills which would authorize the Department of Health Services (DHS) to impose an assessment on Wisconsin's critical access hospitals, beginning in 2010-11, and use the assessment revenue for the following purposes: (a) to increase payments to critical access hospitals under the state's medical assistance (MA) program; (b) to provide additional funding for the physician, dentist, and health care provider loan assistance program administered by the University of Wisconsin System (UW); (c) to provide funding to establish a new rural physician residency assistance program administered by the UW; and (d) to increase revenue to the MA trust fund, which supports general MA benefits costs.

Assembly Bill 770 was introduced on February 24, 2010, and referred to the Assembly Committee on Rural Economic Development, which recommended it for passage on a 7-2 vote on March 5, 2010. The bill was referred to the Joint Committee on Finance on March 5, 2010.

Senate Bill 553 was introduced on February 24, 2010 and referred to the Senate Committee on Public Health, Senior Issues, Long-Term Care, and Job Creation, which recommended it for passage on a vote of 4-1 on March 11, 2010. Senate Bill 553 was referred to the Joint Committee on Finance on March 12, 2010.

BACKGROUND

2009 Wisconsin Act 2 (Act 2) established a provider assessment on all Wisconsin hospitals, other than critical access hospitals and institutions for mental diseases, beginning in fiscal year 2008-09. In any fiscal year, DHS is authorized to assess "eligible" hospitals an amount specified in the Chapter 20 schedule of appropriations. Under Act 28 (the biennial budget act), DHS may assess eligible hospitals $378,694,500 in 2009-10 and $414,507,300 in 2010-11.

DHS collects the current hospital assessment by applying a uniform tax (referred to as the "uniform percentage") to the gross patient revenues of all eligible hospitals in the state. Once collected, the assessment revenue is deposited to the segregated hospital assessment fund. The state's MA program uses a portion of these assessment revenues (and corresponding federal MA matching funds, referred to as federal financial participation, or "FFP") to make additional reimbursement payments to eligible hospitals for the services they provide to MA recipients. For hospitals that serve MA recipients on a fee-for-service basis, the state pays the additional reimbursement directly to the hospital. For hospital services provided to MA recipients enrolled in a health maintenance organization (HMO), the additional reimbursement is paid to the recipient's HMO, which in turn forwards it to the appropriate hospital. The total amount of additional MA reimbursement provided to eligible hospitals through the current hospital assessment mechanism is equal to the assessment amount identified in the Chapter 20 schedule ($414,507,300 for 2010-11) divided by a percentage specified in statute (61.68%), or a total of $672,028,700 (all funds) in 2010-11. Hospital assessment revenues not used to support these additional reimbursement payments to eligible hospitals are transferred to the MA trust fund and used primarily to replace general purpose revenue (GPR) that would otherwise be required to fund general MA benefits.

As indicated, critical access hospitals are currently excluded from the definition of an "eligible" hospital, and therefore are not subject to the current hospital assessment. There are 59 critical access hospitals in Wisconsin. State law defines a critical access hospital by referencing federal law, which specifies that a critical access hospital must be located in an area outside of a metropolitan statistical area (or be located in a rural area of an urban county), be located more than a 35-mile drive from another hospital, and maintain no more than a total of 25 beds to be used exclusively for acute inpatient care. Before January 1, 2006, a hospital could also be certified as a critical access hospital if the state designated it as a necessary provider of health care services to residents in the area. While this latter certification process is no longer available, hospitals that obtained critical access hospital certification by being designated a necessary provider prior to January 1, 2006, can retain their critical access hospital certification, even if they do not satisfy the 35-mile distance requirement.

Prior to January 1, 2010, DHS paid critical access hospitals rates intended to reimburse them for 100% of the costs they incurred to provide covered services to MA recipients. Effective January 1, 2010, DHS reduced those reimbursement rates by 10%. The 10% rate reduction was part of the Department's plan to realize approximately $600 million (all funds) in savings in the MA program during the 2009-11 biennium, as required under Act 28. DHS estimates that the 10% rate reduction to critical access hospitals will, if it remains in effect, generate approximately $10,193,800 (all funds) in savings in 2010-11.

SUMMARY OF BILL

Critical Access Hospital Assessment and MA Reimbursement

The bill would establish a provider assessment on critical access hospitals beginning in state fiscal year 2010-11. Unlike the current hospital assessment, the dollar amount of the critical access

hospital assessment would not be established by law in the Chapter 20 schedule of appropriations. Instead, the bill would direct DHS to impose an assessment on critical access hospitals that is equal to a uniform percentage of each critical access hospital's gross inpatient revenues, as reported to and as determined by DHS. DHS would establish that uniform percentage for both the current hospital assessment and the critical access hospital assessment such that the total amount of assessment revenue collected under the current hospital assessment in a state fiscal year is equal to the amount identified in the Chapter 20 schedule of appropriations for the current hospital assessment. The effect of this provision would be to require DHS to apply the same uniform percentage under both the current hospital assessment and the critical access hospital assessment. Though not identified in the bill, or in current statute, DHS estimates that the uniform percentage in 2010-11 will be approximately 1.6%.

The bill would repeal a provision that excludes critical access hospitals from the definition of an "eligible hospital" for purposes of the current hospital assessment, and the bill would specify that the current hospital assessment applies to eligible hospitals that are not critical access hospitals.

The bill would require critical access hospitals to pay the new assessment in four equal amounts that would be due by September 30, December 31, March 31, and June 30 of each year. As with the current hospital assessment, the bill would give DHS discretion to determine whether a critical access hospital is unable to make a timely payment by the required date, and a determination by DHS that a hospital may not make a delayed assessment payment would be final and not subject to review under Chapter 227 of the statutes.

The bill would establish the critical access hospital assessment fund, defined as a separate nonlapsible trust fund that would consist of all moneys received from the critical access hospital assessment and all moneys recouped in the event the federal government does not provide FFP for a payment required to be made from the critical access hospital assessment fund. The State of Wisconsin Investment Board would have exclusive control of the investment and collection of the principal and interest of all moneys loaned or invested from the critical access hospital assessment fund.

The bill would amend current provisions relating to the current hospital assessment fund to specify that that fund consists, in part, of all moneys received from assessments on hospitals other than critical access hospitals.

The bill would create a DHS appropriation that states that from the critical access hospital assessment fund, all moneys received from the critical access hospital assessment, except money appropriated to the UW to provide additional funding for the physician, dentist, and health care provider loan assistance program and to establish a new rural physician residency assistance program, shall be used for the following purposes: (1) to make payments to critical access hospitals for services provided under the MA program; (2) to make refunds to critical access hospitals for amounts collected under the critical access hospital assessment, and that are used to make payments to critical access hospitals, in the event the federal government does not provide FFP for those payments, and to make refunds to critical access hospitals of any unencumbered moneys in the critical access hospital assessment fund on June 30 of each state fiscal year; and (3) to make a

transfer to the MA trust fund.

Regarding the three categories of payments enumerated in the preceding paragraph, the bill provides the following. First, the bill would require DHS to use a portion of the critical access hospital assessment revenues to pay for services provided by critical access hospitals under the MA program, including services reimbursed on a fee-for-service basis and services provided under a managed care system. The bill further specifies that the total amount of such payments in each state fiscal year, including both the federal and state share of those MA payments, shall be equal to the amount of critical access hospital assessment revenue collected that year divided by 61.68 percent. With respect to the required payments to managed care systems, the bill would require DHS to pay each HMO with which it contracts to provide MA services a monthly amount that the HMO in turn must pay to the appropriate critical access hospital within 15 days after receiving the money from DHS. This requirement mirrors that currently in place with respect to the current hospital assessment. The bill would also modify current provisions relating to the current hospital assessment appropriation to specify that a portion of the revenues collected under the current hospital assessment would be used to pay eligible hospitals other than critical access hospitals for services provided under the MA program, and that the total amount of such payments, including both the federal and state share, would be required to equal the total amount of the current hospital assessment (as established in the Chapter 20 schedule of appropriations) divided by 61.68%. This would amend current law by distinguishing hospitals that receive MA payments under the current hospital assessment from critical access hospitals, and by inserting the word "required" when referring to the payments DHS shall make to those hospitals under the current hospital assessment mechanism.

Second, the bill would authorize DHS to use money in the critical access hospital assessment fund to make refunds to critical access hospitals for amounts collected under the critical access hospital assessment, and that are used to make payments to critical access hospitals, in the event the federal government does not provide FFP for those payments. (Similarly, the bill would require DHS to make refunds to critical access hospitals from the MA trust fund in the event moneys transferred from the critical access hospital assessment fund to the MA trust fund, and used to make payments from the MA trust fund, do not receive FFP from the federal government. The bill would also modify current law provisions relating to the MA trust fund to authorize the payment of these refunds.) Any such refunds, either from the critical access hospital assessment fund or the MA trust fund, would be required to be made in proportion to the percentage of the total assessments collected that each critical access hospital paid.

Third, the bill would require the Secretary of the Department of Administration, in each fiscal year, to transfer from the critical access hospital assessment fund to the MA trust fund an amount equal to the amounts collected under the critical access hospital assessment, less the following: (a) the state's share of the MA payments to critical access hospitals, as provided under the bill; (b) the amounts appropriated to the UW under the bill; and (c) any refunds paid to critical access hospitals from the critical access hospital assessment fund in the event the federal government does not provide FFP for payments made using critical access assessment funds. The bill would also modify current provisions relating to the MA trust fund to allow that fund to receive

this annual transfer from the critical access hospital assessment fund.

The bill would establish a recoupment mechanism for the critical access hospital assessment that is similar to that which exists for the current hospital assessment. Specifically, the bill would provide that if DHS makes a refund to critical access hospitals as a result of failure to obtain FFP from the federal government as described above, it shall recoup the part of the payment for which FFP was not provided. The bill further specifies that moneys recouped for payments made from the critical access hospital assessment fund shall be deposited to that fund, and moneys recouped for payments made from the MA trust fund shall be deposited to that fund. The bill would modify current law relating to the MA trust fund to enable that fund to receive these recouped amounts.

The bill would require DHS, on June 30 of each state fiscal year, to refund to critical access hospitals any unencumbered moneys in the critical access hospital assessment fund.

Under current law, DHS is required to report to the Joint Committee on Finance, by January 1 of each year, the following information for the state fiscal year ending the previous June 30: (a) the amount of assessment each eligible hospital paid; (b) the amount DHS paid each HMO under the assessment mechanism; (c) the total amount each eligible hospital received from HMOs under the assessment mechanism; (d) the total amount of payment increases DHS made, in connection with the hospital assessment mechanism, for inpatient and outpatient hospital services that are reimbursed on a fee-for-service basis; (e) the total amount of payments DHS made to each hospital under the MA program; (f) the portion of capitated payments that DHS made to each HMO under the MA program from appropriation accounts of GPR that is for inpatient and outpatient hospital services; and (g) the results of any audits DHS conducts of HMOs to ensure that HMOs are passing through higher capitation rates to hospitals, and any actions taken by DHS as a result of the audits. The bill would require DHS to include the same information regarding the critical access hospital assessment in its report to the Joint Committee on Finance.

The bill would require DHS to submit a state MA plan amendment to the U.S. Department of Health and Human Services (DHHS) that provides for the critical access hospital assessment and for the expenditure of revenue from the critical access hospital assessment. The bill would also provide that if the DHHS Secretary disapproves the state MA plan amendment, DHS shall refund to critical access hospitals all of the moneys collected from the critical access hospital assessment in the fiscal biennium in which this subsection of the bill would take effect, and DHS shall stop collecting moneys under the critical access hospital assessment.

The bill specifies that none of its provisions would affect any requirements under s. 16.46 of the statutes, which relates to the preparation and contents of the biennial state budget. In addition, the bill would require DHS and the Department of Administration to review, re-estimate, and request general purpose revenues for payments to critical access hospitals under the MA program as needed.

The bill would increase MA benefits funding by $3,680,500 SEG from the MA trust fund in 2010-11.

Physician and Dentist and Health Care Provider Loan Assistance Programs

Current Law. Under the physician and dentist loan assistance program, the UW Board of Regents may repay up to $50,000 in education loans on behalf of a physician or dentist who agrees to practice in one or more eligible practice areas or dental health shortage areas in this state. For the purpose of this program, the definition of physician is limited to physicians who specialize in family practice, general surgery, internal medicine, obstetrics, pediatrics, or psychiatry and the definition of dentist is limited to dentists who practice general or pediatric dentistry. Under the health care provider loan assistance program, the Board may repay up to $25,000 in education loans on behalf of a health care provider who agrees to practice in one or more eligible practice areas in this state. To be eligible for repayment, the loans must be for education related to the physician's, dentist's, or health care provider's field of practice.

To be eligible for loan repayment through these programs, the physician, dentist, or health care provider must enter into a written agreement with the Board in which he or she agrees to practice at least 32 clinic hours per week for three years in an eligible practice area. Physicians and dentists must also agree to care for patients who are insured or for whom health or dental health benefits are payable under Medicare, medical assistance, or any other governmental program. Physicians and health care providers who meet additional requirements may also be eligible for federally funded loan repayments through the expanded loan assistance program. The agreement must also specify that the Board will make repayments subject to the availability of state funds for this purpose.

Loans to physicians and dentists are repaid as follows: (1) 40% of the principal up to $20,000 during the first year; (2) 40% of the principal up to $20,000 during the second year; and (3) 20% of the principal up to $10,000 in the third year. Loans to health care providers are repaid as follows: (1) 40% of the principal up to $10,000 during the first year; (2) 40% of the principal up to $10,000 during the second year; and (3) 20% of the principal up to $5,000 in the third year.

In the case that the number of eligible applicants exceeds the number of new physicians, dentists, and health care providers that can be funded through these programs, the Board shall select applicants based on the following criteria: (1) the degree to which there is an extremely high need for medical or dental care in the selected practice area; (2) the likelihood that the physician, dentist, or health care professional will stay in the selected practice area beyond the loan repayment period; (3) the per capita income of the selected area; (4) the financial or other support for physician, dentist, and health care provider recruitment provided by individuals, organizations, or local governments in the selected practice area; (5) the geographic distribution of current program participants and program applicants; and (6) other considerations as specified by the Board.

Current funding for these programs is $488,700 annually from tribal gaming revenues. In addition, the state receives $300,000 annually through a federal matching grant program to fund loan repayments through the expanded loan assistance program. It is estimated that during the 2010 calendar year loan repayments will be made on behalf of 58 physicians, dentists, and health care providers.

Summary of Bill. The bill would modify the existing loan assistance programs for physicians, dentists, and health care providers such that physicians, dentists, and health care providers who agree to practice in a rural area would also be eligible for loan repayment under those programs. For the purpose of these programs, a rural area is defined as: (1) a city, town, or village in this state that has a population of less than 20,000 and that is at least 15 miles from any city, town, or village that has a population of at least 20,000; or (2) an area in this state that is not an urbanized area, as defined by the U.S. Census Bureau. Dentists and health care providers who agree to practice in rural areas would be eligible for loans repayments of up to $50,000 and $25,000, respectively, as under the existing programs. Physicians who agree to practice in rural areas would be eligible for loan repayments of up to $100,000. Loans to physicians practicing in rural areas would be repaid as follows: (1) 40% of the principal up to $40,000 during the first year; (2) 40% of the principal up to $40,000 during the second year; and (3) 20% of the principal up to $20,000 in the third year.

The bill would provide $250,000 annually beginning in 2010-11 from funds transferred from the critical access hospital assessment fund for the purpose of providing loan repayments through the physician and dentist and health care provider loan assistance programs. This funding would be provided in a new, biennial appropriation under the UW System. This funding could only be used to fund loan repayments for physicians, dentists, and health care providers who agree to practice in rural areas. To the extent that physicians, dentists, and health care providers funded through this appropriation meet the requirements of the expanded loan assistance program this funding may be used to leverage additional federal funds.

The bill would also modify language regarding the selection of applicants in cases where the number of applicants exceeds the number of applicants that can be funded to include rural areas among the eligible practice areas. In addition, the bill would require the Board to identify rural areas with extremely high need for medical or dental care. This requirement would be in addition to the current law requirement that the Board identify eligible practice and dental health shortage areas with extremely high need for medical or dental care.

Rural Residency Assistance Program

The bill would create a rural physician residency assistance program under the UW Board of Regents. Through this program, the UW School of Medicine and Public Health department of family medicine would establish and support residency positions that are located in rural areas or that include a rural rotation of at least eight weeks. "Rural area" and "physician" would have the same definition as under the physician and dentist and health care provider loan assistance programs, provided above. Under the bill, $750,000 annually beginning in 2010-11 would be provided from funds transferred from the critical access hospital assessment fund to support this program. This funding would be provided in a new, biennial appropriation under the UW System.

To be eligible for support through this program, a residency position must either be in a hospital that is located in a rural area or in a clinic staffed by physicians that admits patients to a hospital in a rural area. In addition, the rural rotation component of a residency position must have

begun after June 30, 2010. Preference would be given to residency programs that actively recruit graduates of the UW School of Medicine and Public Health and the Medical College of Wisconsin.

The Board would be required to submit a plan for increasing the number of physician residency programs that include a majority of training experience in a rural area to the Rural Wisconsin Health Cooperative, the Wisconsin Hospital Association, and the Wisconsin Medical Society by December 1 of each year. This plan would include a detailed proposed budget for expending the moneys appropriated for the rural physician residency assistance program and would demonstrate that the funding provided would not supplant existing funding. The Board would be required to consider comments made by those organizations in formulating the final program budget.

In addition, the Board would be required to submit a report by December 1 of each year to the Joint Committee on Finance. This report would provide the number of residency positions that included a majority of training experience in a rural area in each fiscal year beginning with 2009-10. In addition, the report would include: (1) the number of residency positions funded in whole or in part through the rural physician residency assistance program in the previous fiscal year; (2) the eligibility criteria met by each residency position and the hospital or clinic with which the position is affiliated; (3) the medical school attended by each physician resident; (4) the year the Accreditation Council for Graduate Medical Education certified each residency position; and (5) the reason each residency position had not been funded.

Initial Applicability and Effective Date

The provisions that would require DHS to use a portion of the critical access hospital assessment revenues to pay for services provided by critical access hospitals under the MA program, including services reimbursed on a fee-for-service basis and services provided under a managed care system, would first apply to services provided by critical access hospitals on July 1, 2010. The bill specifies an effective date of July 1, 2010.

FISCAL EFFECT

It is estimated that the bill would do the following: (a) increase MA benefits funding by $27,686,500 ($9,579,500 SEG and $18,107,000 FED) in 2010-11; and (b) increase SEG revenues by $10,579,500 in 2010-11. All of this additional revenue would be initially deposited to the new critical access hospital assessment fund, but $3,680,500 would be transferred to the MA trust fund. (Consistent with the current hospital assessment, the amount that would be transferred to the MA trust fund would be part of the new critical access hospital assessment appropriation, and would therefore be "double counted" in the Chapter 20 appropriation schedule.) The actual increase in MA benefits funding would be determined by the revenue DHS would collect from the assessment, which would be based on critical access hospitals' gross inpatient revenue for hospital fiscal years that ended in calendar year 2009.

In addition, the bill would provide $1,000,000 SEG from the critical access hospital

assessment fund in 2010-11 to fund a new rural residency assistance program ($750,000 SEG) and to increase support for the physician and dentist and health care providers loan assistance program ($250,000 SEG).

A summary of the estimated state fiscal effect of the bill is provided in Attachment 1.

Attachment 2 shows the assessment's estimated impact on each critical access hospital in 2010-11, based on data available on each hospital's gross inpatient revenue and MA services provided in hospital fiscal years that ended in 2008 (the last year for which this information is available). Column A in Attachment 2 shows the assessment payments each hospital is projected to make in 2010-11. The actual assessment payments in 2010-11 will differ from the amounts shown in Column A for several reasons, including changes in the amount of gross inpatient revenues. Column B shows the additional MA reimbursement each critical access hospital is projected to receive in 2010-11 as a result of the new assessment. The actual MA reimbursements in 2010-11 will differ due to changes in MA caseloads. Column C shows the projected net benefit (loss) that would result from the new assessment in 2010-11 for each critical access hospital.

Attachment 3 shows how each critical access hospital would be impacted in 2010-11 if, in addition to instituting the critical access hospital assessment, DHS also reversed the 10% rate reduction to critical access hospitals, effective July 1, 2010. As noted, DHS imposed that 10% reduction in January, 2010, as part of its rate reform savings plan. It is the understanding of this office that DHS intends to reverse that 10% rate reduction, effective July 1, 2010, if the critical access hospital assessment that would be created under the bill is enacted. Attachment 3 shows the projected impact to each critical access hospital in 2010-11 from the combination of the new assessment and the reversal of that 10% reduction. Column A shows the projected net benefit to each hospital from the critical access hospital assessment in 2010-11 (from Column C in Attachment 2). Column B shows the estimated impact to each critical access hospital in 2010-11 if the 10% rate reduction is reversed effective July 1, 2010. Column C shows the combined impact in 2010-11 of the critical access hospital assessment and the reversal of the 10% rate reduction. In effect, Column C in Attachment 3 shows the projected net impact of the critical access hospital assessment and the reversal of the 10% rate reduction, compared to current law (current law being no assessment and the 10% rate reduction).

Attachment 4 summarizes the projected net fiscal impact to critical access hospitals (in the aggregate) and to the MA program in 2010-11 if the critical access hospital assessment is implemented and the 10% rate reduction is reversed, effective July 1, 2010. The projected net benefit to critical access hospitals is $16,663,600. That total consists of the projected net benefit from the assessment ($6,469,800) and the additional MA reimbursement if the 10% rate reduction is reversed ($10,193,800).

The projected net benefit to the MA program in 2010-11 is $153,400 GPR. That amount is calculated by taking the projected transfer to the MA trust fund ($3,680,500) and subtracting the GPR savings that would be lost ($3,527,100) if the 10% rate reduction is reversed. This projected positive net impact in 2010-11 is due in part to the temporarily-enhanced FMAP the state is forecast to receive that year under the American Recovery and Reinvestment Act of 2009. Preliminary

estimates indicate that there would be a negative net impact in 2011-12 of approximately $1 million GPR should the state's FMAP return to a more typical rate of approximately 60%. The precise amount of that net impact will depend on a variety of factors, including changes in critical access hospitals' gross inpatient revenues.

Prepared by: Eric Peck and Emily Pope
Attachments

ATTACHMENT 1

Estimated State Effect of Critical Access Hospital Assessment
Fiscal Year 2010-11

	SEG/SEG-REV	FED	Total
Assessment Revenue*	$10,579,500	$0	$10,579,500
Spending Items			
Increased Payments to Critical Access Hospitals**	$5,899,000	$11,150,200	$17,049,200
Rural Physician Residency Assistance Program	750,000	0	750,000
Physician and Dentist and Health Care Provider Loan Assistance***	250,000	0	250,000
Subtotal	$6,899,000	$11,150,200	$18,049,200
Transfer to the MA Trust Fund to Restore 10% Rate Reduction to Critical Access Hospitals under the DHS Rate Reform Project ($3,527,100 SEG) and to Support General MA Benefits ($153,400 SEG)	$3,680,500	$6,956,800	$10,637,300
Total Expenditure Authority (The SEG Total includes New Spending from the Critical Access Hospital Fund ($6,899,000), the Amount Transferred to the MA Trust Fund ($3,680,500), and Additional Expenditure Authority from the MA Trust Fund ($3,680,500).	$14,260,000	$18,107,000	$32,367,000

*Estimated assessment amount is based on applying the current hospital assessment rate (approximately 1.6077%) to the gross inpatient revenues of critical access hospitals for hospital fiscal years ending in 2008 ($658,052,000). However, DHS would implement the assessment by applying the assessment rate to gross inpatient revenues of critical access hospitals for fiscal years ending in 2009.

**Amount is $102,900 less than the increased payments DHS would be required to make under the bill, which is calculated by dividing the assessment amount ($10,579,500) by a statutorily-specified percentage (.6168), which would yield $17,152,200. The difference reflects reductions DHS would make to ensure that hospitals were not reimbursed under MA in an amount that exceeds their charges.

*** These funds may be used to leverage additional federal matching funds for the expanded loan assistance program.

ATTACHMENT 2

Critical Access Hospital	City	**Column A** Assessment Payments	**Column B** Additional MA Reimbursement	**Column C** Assessment Net Impact (B-C)
Amery Regional Medical Center	Amery	$273,397	$577,233	$303,836
Arcadia	Arcadia	60,517	162,160	101,643
Baldwin Area Medical Center, Inc.	Baldwin	166,710	367,267	200,557
Barron Memorial Medical Center	Barron	155,188	241,692	86,504
Berlin Memorial Hospital	Berlin	381,124	555,655	174,531
Black River Memorial Hospital	Black River Falls	185,338	413,406	228,068
Bloomer Medical Center	Bloomer	101,847	27,138	- 74,709
Bond Health Center	Oconto	6,288	0	- 6,288
Burnett Medical Center, Inc.	Grantsburg	73,702	173,239	99,537
Calumet Medical Center Assn., Inc.	Chilton	97,426	106,753	9,327
Chippewa Valley Critical Access Hospital	Durand	121,799	23,888	- 97,911
Columbus Community Hospital	Columbus	215,621	104,861	- 110,760
Community Memorial Hospital	Oconto Falls	262,606	487,962	225,356
Cumberland Memorial Hospital	Cumberland	176,933	337,669	160,736
Door County Memorial Hospital	Sturgeon Bay	401,001	291,576	- 109,425
Eagle River Memorial Hospital	Eagle River	76,027	70,025	- 6,002
Edgerton Hospital and Health Services	Edgerton	110,913	86,573	- 24,340
Flambeau Hospital, Inc.	Park Falls	104,369	125,899	21,530
Good Samaritan Health Center of Merrill	Merrill	151,128	139,856	- 11,272
Grant Regional Health Center, Inc.	Lancaster	80,209	115,173	34,964
Hayward Area Memorial Hospital	Hayward	260,181	604,735	344,554
Holy Family Hospital	New Richmond	232,604	194,133	- 38,471
Hudson Memorial Hospital, Inc.	Hudson	274,339	237,361	- 36,978
Indianhead Medical Center	Shell Lake	45,266	109,459	64,193
Ladd Memorial Hospital	Osceola	110,675	112,168	1,493
Langlade Memorial Hospital	Antigo	261,897	887,057	625,160
Memorial Health Center	Medford	135,961	497,565	361,604
Memorial Hospital, Inc.	Neillsville	159,329	230,185	70,856
Memorial Hospital of Boscobel	Boscobel	177,622	244,491	66,869
Memorial Hospital of Lafayette County	Darlington	71,631	72,514	883
Memorial Medical Center	Ashland	384,462	1,142,200	757,738
Mercy Walworth Hospital and Jacob Bast	Lake Geneva	86,552	77,211	- 9,341
Moundview Memorial Hospital	Friendship	54,995	102,076	47,081
Myrtle Werth Hospital, Inc.	Menomonie	284,644	848,027	563,383
New London Medical Center	New London	156,992	418,358	261,366
Osseo Medical Center-Mayo Health System	Osseo	60,164	29,286	- 30,878
Our Lady of Victory Hospital	Stanley	128,901	169,087	40,186
Prairie du Chien Memorial Hospital	Prairie du Chien	197,822	269,296	71,474
Reedsburg Area Medical Center	Reedsburg	362,363	312,129	- 50,234
Ripon Medical Center	Ripon	125,347	145,846	20,499
River Falls Area Hospital	River Falls	364,947	164,181	- 200,766
Riverside Medical Center	Waupaca	199,963	508,196	308,233
Rusk County Memorial Hospital and NH	Ladysmith	121,544	372,725	251,181
Sacred Heart Hospital	Tomahawk	83,639	93,426	9,787
Shawano Medical Center	Shawano	285,778	998,096	712,318
Southwest Health Center	Platteville	224,837	312,103	87,266
Sparta Hospital	Sparta	64,016	324,627	260,611
Spooner Health System	Spooner	102,620	331,709	229,089
St. Croix Regional Medical Center	St. Croix Falls	316,007	344,501	28,494
St. Joseph's Community Health Services	Hillsboro	118,342	86,476	- 31,866
St. Mary's Hospital	Superior	96,882	338,673	241,791
Stoughton Hospital Association	Stoughton	297,829	283,373	- 14,456
The Richland Hospital, Inc.	Richland Center	281,160	262,054	- 19,106
Tomah Memorial Hospital	Tomah	160,339	576,991	416,652
Tri-County Memorial Hospital, Inc.	Whitehall	65,337	59,395	- 5,942
Upland Hills Health	Dodgeville	212,264	248,249	35,985
Vernon Memorial Hospital	Viroqua	468,131	312,036	- 156,095
Waupun Memorial Hospital	Waupun	269,239	190,146	- 79,093
Wild Rose Community Memorial Hospital	Wild Rose	72,739	131,090	58,351
Total		$10,579,503	$17,049,256	$6,469,753

ATTACHMENT 3

Critical Access Hospital	City	Column A Assessment Net Impact	Column B Reversed 10% Rate Reduction	Column C Combined Impact (A+B)
Amery Regional Medical Center	Amery	$303,836	$251,572	$555,408
Arcadia	Arcadia	101,643	68,687	170,330
Baldwin Area Medical Center, Inc.	Baldwin	200,557	178,225	378,782
Barron Memorial Medical Center	Barron	86,504	136,865	223,369
Berlin Memorial Hospital	Berlin	174,531	272,720	447,251
Black River Memorial Hospital	Black River Falls	228,068	253,335	481,403
Bloomer Medical Center	Bloomer	- 74,709	30,947	- 43,762
Bond Health Center	Oconto	- 6,288	19,411	13,123
Burnett Medical Center, Inc.	Grantsburg	99,537	95,837	195,374
Calumet Medical Center Assn., Inc.	Chilton	9,327	48,292	57,619
Chippewa Valley Critical Access Hospital	Durand	- 97,911	42,846	- 55,065
Columbus Community Hospital	Columbus	- 110,760	114,374	3,614
Community Memorial Hospital	Oconto Falls	225,356	224,508	449,864
Cumberland Memorial Hospital	Cumberland	160,736	172,401	333,137
Door County Memorial Hospital	Sturgeon Bay	- 109,425	186,432	77,007
Eagle River Memorial Hospital	Eagle River	- 6,002	81,886	75,884
Edgerton Hospital and Health Services	Edgerton	- 24,340	56,650	32,310
Flambeau Hospital, Inc.	Park Falls	21,530	127,673	149,203
Good Samaritan Health Center of Merrill	Merrill	- 11,272	122,954	111,682
Grant Regional Health Center, Inc.	Lancaster	34,964	103,204	138,168
Hayward Area Memorial Hospital	Hayward	344,554	280,882	625,436
Holy Family Hospital	New Richmond	- 38,471	239,036	200,565
Hudson Memorial Hospital, Inc.	Hudson	- 36,978	245,365	208,387
Indianhead Medical Center	Shell Lake	64,193	51,463	115,656
Ladd Memorial Hospital	Osceola	1,493	123,287	124,780
Langlade Memorial Hospital	Antigo	625,160	538,645	1,163,805
Memorial Health Center	Medford	361,604	192,789	554,393
Memorial Hospital, Inc.	Neillsville	70,856	96,630	167,486
Memorial Hospital of Boscobel	Boscobel	66,869	147,555	214,424
Memorial Hospital of Lafayette County	Darlington	883	57,735	58,618
Memorial Medical Center	Ashland	757,738	745,749	1,503,487
Mercy Walworth Hospital and Jacob Bast	Lake Geneva	- 9,341	157,369	148,028
Moundview Memorial Hospital	Friendship	47,081	109,880	156,961
Myrtle Werth Hospital, Inc.	Menomonie	563,383	299,855	863,238
New London Medical Center	New London	261,366	186,479	447,845
Osseo Medical Center-Mayo Health System	Osseo	- 30,878	26,709	- 4,169
Our Lady of Victory Hospital	Stanley	40,186	92,044	132,230
Prairie du Chien Memorial Hospital	Prairie du Chien	71,474	139,693	211,167
Reedsburg Area Medical Center	Reedsburg	- 50,234	271,719	221,485
Ripon Medical Center	Ripon	20,499	82,129	102,628
River Falls Area Hospital	River Falls	- 200,766	200,829	63
Riverside Medical Center	Waupaca	308,233	205,587	513,820
Rusk County Memorial Hospital and NH	Ladysmith	251,181	189,253	440,434
Sacred Heart Hospital	Tomahawk	9,787	67,622	77,409
Shawano Medical Center	Shawano	712,318	531,301	1,243,619
Southwest Health Center	Platteville	87,266	260,874	348,140
Sparta Hospital	Sparta	260,611	123,665	384,276
Spooner Health System	Spooner	229,089	155,763	384,852
St. Croix Regional Medical Center	St. Croix Falls	28,494	232,489	260,983
St. Joseph's Community Health Services	Hillsboro	- 31,866	73,533	41,667
St. Mary's Hospital	Superior	241,791	264,395	506,186
Stoughton Hospital Association	Stoughton	- 14,456	163,704	149,248
The Richland Hospital, Inc.	Richland Center	- 19,106	236,435	217,329
Tomah Memorial Hospital	Tomah	416,652	218,982	635,634
Tri-County Memorial Hospital, Inc.	Whitehall	- 5,942	40,511	34,569
Upland Hills Health	Dodgeville	35,985	201,097	237,082
Vernon Memorial Hospital	Viroqua	- 156,095	182,219	26,124
Waupun Memorial Hospital	Waupun	- 79,093	104,938	25,845
Wild Rose Community Memorial Hospital	Wild Rose	58,351	66,796	125,147
Total		$6,469,753	$10,193,825	$16,663,578

ATTACHMENT 4

Summary of Projected Effect on Critical Access Hospitals and the MA Program Fiscal Year 2010-11

Additional MA Payments to Critical Access Hospitals under Assessment	$17,049,300
Less: Assessments Paid by Critical Access Hospitals	10,579,500
Net Benefit to Critical Access Hospitals from Assessment	$6,469,800
Net Benefit to Critical Access Hospitals from Reversing 10% Rate Reduction	10,193,800
Projected Combined Net Benefit to Critical Access Hospitals, Compared to Current Law	$16,663,600
Assessment Revenues Minus GPR Share of Additional MA Payments	$4,680,500
Less: $1 Million to New UW Appropriations	1,000,000
Projected Transfer to the MA Trust Fund	$3,680,500
Less: Lost GPR Savings Due to Reversal of 10% Rate Reduction	3,527,100
Projected Net Budgetary Impact to MA Program in 2010-11	$153,400