SECTION 5: ANALYSIS OF WYOMING DATA

Overview

This section of our report provides some general background information about Wyoming hospitals, as well as financial information about Wyoming hospitals, including a discussion of charity care and bad debt, and then moves on to the discussion of the costs of the uninsured and unreimbursed trauma care and catastrophic care.

Background

To place the evaluation of trauma and catastrophic care in their proper context, it is also necessary to consider how other financial issues affect Wyoming hospitals. The evaluation of this combined data will assist in establishing state-specific priorities if additional funding is made available.

In 2003, Wyoming hospitals provided approximately 51,800 admissions and 660,841 outpatient visits annually, representing approximately $724.9 million in total revenue and $48 million in net revenue.[1] Additionally:

- *Bed Size:* More than one-half of Wyoming's hospitals have fewer than 50 beds, and one-half of the hospitals have an average daily census of 30 or less.[2] This relatively low number of beds and utilization is a reflection of the rural and frontier nature of this state.

- *Critical Access Hospital Status:* Twelve of Wyoming's 25 acute care general hospitals have a critical access hospital designation. This special status is designed to help relieve the financial strain on small rural hospitals and exempts them from the Medicare Prospective Payment Systems for inpatient and outpatient services, allowing for Medicare reimbursement at 101 percent of their reasonable costs. Critical access hospitals are required to make available 24-hour emergency care services, provide no more than 25 beds for acute inpatient care and maintain an annual average length of stay of no longer than 96 hours. These restrictions on numbers of beds and length of stay limit the service offerings in critical access hospitals.[3]

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[1] Gross patient revenues less deductions plus tax revenue [Source: Wyoming Hospital Association, "Wyoming Hospitals' Financial Data 1990-2003"].

[2] Based on days hospitals reported on Wyoming's fiscal year 2003 Medicare cost reports for the bed categories included in the adult, pediatric acute, nursery, intensive care, nursing facility, psychiatric and rehabilitation unit and hospice beds.

[3] The Center for Medicare and Medicaid Services, "Critical Access Hospital Webpage." Available online: http://www.cms.hhs.gov/providers/cah/.

While Wyoming Medicaid reimburses critical access hospitals like any other hospital for inpatient hospital services, Medicaid pays critical access hospitals for outpatient hospital services 70 percent of their billed charges, which in some cases exceeds 100 percent of their costs, as opposed to the Medicaid outpatient hospital fee schedule.

- *Levels of Trauma Care:* While all of Wyoming's hospitals have some level of trauma care designation, there are no Level I Trauma Centers and only two hospitals are Level II Trauma Centers (Regional Trauma Centers) – Wyoming Medical Center and United Medical Center. While six hospitals provide the lowest level of trauma care as Trauma Receiving Facilities, these hospital are critical to receiving and stabilizing trauma care patients and transferring critically injured patients to a higher level care trauma hospital (Appendix D).

- *Use of Out-of-State Services:* For many of Wyoming's residents, out-of-state facilities are more accessible. An analysis based on the patient's county of origin indicates that hospitals in neighboring states accounted for an estimated 16 percent of all Wyoming residents' hospitalizations.[4]

- *Managed Care:* Due to its rural and frontier nature, there is little or no managed care penetration in Wyoming.[5]

Wyoming hospitals currently receive funding from a variety of services, including:

- Public payors such as Medicare, Medicaid, the State Children's Health Insurance Program, Wyoming's High Risk Pool and Worker's Compensation Programs, which include in addition to standard inpatient and outpatient payments:

  - Medicaid disproportionate share hospital payments

  - Enhanced inpatient and outpatient Medicaid payments (qualified rate adjustment payments) to government-owned or operated hospitals using an intergovernmental transfer mechanism

- Private payors such as Blue Cross Blue Shield of Wyoming

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[4] The sources of this all-payor data are: Solucient, Inc. for Colorado (2003) and Utah (2002), Nebraska Hospital Association (2003), South Dakota Hospital Association (2003) and Montana Hospital Association (2003). These datasets include acute care, rehabilitation and psychiatric discharges, but not discharges from hospital-based skilled nursing facilities or swing beds.

[5] Kaiser Family Foundation, "Number of HMOs, 2003." Available online: http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=compare&category=Managed+Care+%26+Health+Insurance&subcategory=HMOs&topic=Number+of+HMOs.

- Out-of-pocket payments for deductibles, copayments and from the uninsured

- County funding – fifteen of Wyoming's hospitals receive local tax support

From our analysis of inpatient hospital services using SFY 2002 and 2003 inpatient discharge data from the Wyoming Hospital Discharge Database, we made the following general observations regarding inpatient hospital discharges and costs:

- Trauma care discharges represented approximately nine percent of total discharges and 12 to 14 percent of total charges and estimated costs (Appendix I, Table 5.1).

- The overall estimated average cost per discharge[6] was $5,734 and $5,775 for SFYs 2002 and 2003, respectively (Appendix I, Table 5.1).[7] The estimated average cost per discharge varied by provider, ranging from $1,576 to $7,415.

- The estimated average cost for all trauma care discharges ($8,030 in 2002 and $7,772 in 2003) was more than 35 percent higher than the average cost per discharge for all services (Appendix I, Table 5.1). This average includes trauma care patients that were received at a Wyoming hospital with a lower level of trauma designation, and then transferred to another hospital or out-of-state.

- In 2003, Medicare was the primary payor for 35 percent of all discharges, followed by commercial payors, with 31 percent of discharges (Appendix I, Table 5.2).

Costs of Providing Care to the Uninsured

The provision of hospital services to the uninsured is a topic of great interest and, as discussed above, uncompensated care, often the result of lack of insurance, is not a focus of this study. Overall hospital financial well-being, however, is a focus of this study, and it is important to understand the levels of uncompensated care in the hospital system. Uncompensated care can include some trauma and catastrophic care, as well as uninsured care, charity care and bad debt.

The provision of uncompensated care started with the 1948 Hospital Survey and Construction Act, which is also known as the Hill-Burton Act. Under this Act, hospitals that received federal capital funds had to provide uncompensated care over a 20-year period equal to the lower of three percent of the hospital's annual operating costs or 10 percent of the federal assistance the

[6] Excludes physician professional fees and non-allowable Medicare costs.

[7] The February 2004 Trauma Care Report (based on a Wyoming Medical Center Report) noted that the American Hospital Association data from 2001 shows that the average cost per stay in Wyoming was $11,618. This cost per stay appears to include all inpatient and outpatient costs, as opposed to the inpatient Medicare-allowable costs included in this per discharge estimate.

hospital received.[8] While few hospitals remain under the Hill-Burton charity care obligations, many hospitals continue to provide a safety net for the poor and uninsured through uncompensated and charity care, specifically:[9]

- Federal law requires hospitals that receive Medicare and Medicaid patients to examine all patients seeking care in hospital emergency rooms (Emergency Medical Treatment and Active Labor Act, or EMTALA). Hospitals may not transfer or otherwise turn away patients from an emergency room if these patients have not been deemed stable through a medical screening examination.

- States require that nonprofit and public hospitals provide some level of community benefit to maintain their tax-exempt status; these hospitals often include the provision of care for the poor in their public or nonprofit mission.

Approximately 14 percent of Wyoming's residents (approximately 70,000 people) are uninsured, representing about 15 percent of all adults and 13 percent of children 18 years old and younger.[10] While coverage for low-income children and families is available through the State's Medicaid and State Children's Health Insurance Program (EqualityCare and KidCareCHIP), there are many low-income families and individuals without insurance that have incomes that are above the Medicaid and SCHIP levels. Hospitals provide care to the uninsured through charity care or uncompensated care that, on average, represents six percent of hospital expenses.[11]

Bad debt and charity care, sometimes referred to jointly as uncollectibles, can be an indicator of how much uncompensated care a hospital is providing and is a reflection of the care provided to the uninsured. While all hospitals provide some level of bad debt and charity care, uncollectibles can negatively impact a hospital's financial health. Wyoming hospitals provided approximately $66 million in bad debt and charity care *charges* in 2003, a 26 percent increase from 2001.[12]

We conducted an analysis of bad debt and charity care data collected by the Wyoming Hospital Association and of hospital financial benchmarking information (from the HARA, described in

[8] Blewett, L., Davidson, G., Brown, M. and Maude-Griffin, R, "Hospital Provision of Uncompensated Care and Public Program Enrollment," *Medical Care Research and Review, Volume 60, No. 4.* (December 2004) 510-511.
[9] Ibid.
[10] The Center for Rural Health Research and Education, University of Wyoming, "Wyoming State Planning Grant Research Report to the Task Force," (October 1, 2003) I-4.
[11] Blewett, L., Davidson, G., Brown, M. and Maude-Griffin, R, "Hospital Provision of Uncompensated Care and Public Program Enrollment," *Medical Care Research and Review, Volume 60, No. 4.* (December 2004) 511.
[12] Data provided through Electronic correspondence from Bob Kidd, President of the Wyoming Hospital Association (September 9, 2004).

Section 1) and made the following observations:

- Bad debt and charity care account for a higher proportion (six percent) of hospital gross revenue[13] in Wyoming as compared to hospitals nationally (five percent) and in the Northwest Region (three percent).[14]

- Bad debt accounts for a larger percent of Wyoming hospitals' uncollectibles (i.e., charity care is a smaller percent of gross revenue in Wyoming then nationally or in the Northwest Region) as compared to hospitals nationally (Appendix I, Figure 5.1).

Six percent of all SFY 2002 and 2003 inpatient hospital costs ($32 million) in the Wyoming Hospital Discharge Database are unreimbursed (primary payor of "medically indigent" or "self-pay" (Appendix I, Table 5.3). These discharges represent 11 percent of total trauma cases and charges.

Unreimbursed Trauma Care

According to the most recent SFY Trauma Registry data, there were a total of 1,185 trauma care patients, representing $19,822,427 in charges and $5,204,538 in payments. Because the Trauma Registry does not contain the detailed claims information necessary to estimate costs on the departmental level, we estimated costs by multiplying all charges by a statewide cost-to-charge ratio of 0.5356.[15] Estimated costs equal approximately $10,616,891, resulting in total unreimbursed costs of $5,412,354 (51 percent of costs).

Assuming that we have only one-fourth of the total trauma care discharges (see Section I for discussion of Trauma Registry data limitations), we project that unreimbursed trauma care costs could be $21,649,416. We estimated costs for the charges in the Trauma Registry ($19,822,427 * 53.56 percent), and then, under the assumption that those costs only represented one fourth of all trauma care for that year, multiplied those costs by four to obtain an annual estimate.

There were additional uncompensated trauma care costs that are not identified in the Trauma Registry Database or the Wyoming Hospital Discharge Database. These costs are:

- *Physician compensation associated with direct trauma care patient services* – Estimated costs in the Wyoming Hospital Discharge database do not include physician compensation related to direct patient care, which is considered a non-allowable Medicare cost on the Medicare cost report because it is billed through Medicare Part

[13] Revenue from services rendered at full established rates (charges).
[14] HARA data defines the Northwest Region as the following States: Alaska, Idaho, Montana, Oregon, Washington and Wyoming.
[15] Total estimated SFY 2003 costs (as calculated by Solucient in the Wyoming Hospital Discharge Database) divided by total SFY 2003 charges.

B on a separate claim form. A review of the Medicare 2003 cost reports, for all Wyoming hospitals, indicates that total non-allowable physician compensation is approximately $23 million; it is not possible to determine what portion of that compensation is directly related to physician care for trauma care patients.

- *Charges for trauma team activation* – These charges, recorded on the hospital claims form using the revenue code series 680-689, represent the notification of key hospital personnel in response to triage information from pre-hospital caregivers in advance of the patient's arrival.[16] For SFY 2003, charges for these services totaled $284,297.[17]

- *Physician stipends to be on-call for patient care* (regardless of whether or not a trauma patient is present). A limited survey of Wyoming hospital representatives indicates that on-call stipends can range from $350 to $600 per surgeon per day. The types of physicians on-call include: general surgeons, trauma surgeons, neurosurgeons and orthopedic surgeons. One hospital indicated that it does not plan to continue these stipends after January 31, 2005 due to the fiscal stress this places on the hospital.

- *Unreimbursed air ambulance costs* – A preliminary estimate by the Wyoming Medical Center indicated that, for trauma care patients,[18] the hospital had unreimbursed air ambulance costs of approximately $251,700 in SFY 2003.[19]

Hospitals incur specific administrative costs for participating in the Trauma Care Program (i.e., data collection and trauma service coordination). These costs are generally recorded in the Medicare cost report as allowable costs with some exceptions. The Trauma Program estimates that administrative costs for delivering trauma care would be as follows for each trauma designation:[20]

- Regional Trauma Centers - $936,824
- Area Trauma Hospitals - $702,618
- Community Trauma Hospitals - $421,571
- Trauma Receiving Facility - $168,628

[16] Department of Health and Human Services Centers for Medicare and Medicaid Services, *Medicare Transmittal 149, General Instructions for Completion of Form CMS-1450 for Billing (*April 23, 2004).
[17] Electronic correspondence received from Ken Taylor, Solucient Inc., October 8, 2004.
[18] Defined using ICD-9 codes 800-904.99, 925 through 929.9 and 940-959.99 [Source: American Medical Association, *Physician ICD-9-CM 2004, Volumes 1 and 2* (Ingenix, Inc., 2003) 249-266, 269-274].
[19] Lorenzen, C., Telephone interview (October 13, 2004).
[20] Electronic correspondence received from Maggie Cleveland, Trauma Care Program Coordinator, October 12, 2004.

These costs include trauma training for nurses and other medical professionals, wages and benefits for trauma coordinators and other trauma personnel, physician stipends and large equipment items. These estimates do not include travel for meetings, education, injury prevention activities and trauma center outreach activities.

Hospital Survey of High-Cost Discharges

Because only 73 percent of hospitals that responded to the survey provided outpatient hospital data, we are presenting the results of the inpatient and outpatient hospital services separately.

Overall, our analysis of inpatient hospital services, including readmissions data for those hospitals that submitted this information, indicates that:

- Commercial payors pay more than public payors per discharge, as measured by a payment to charge ratio of 88 percent as compared to approximately 35 percent for Medicare and Medicaid (Appendix J). Selected hospital representatives have indicated that these ratios may reflect generally higher payments by car insurance companies, who may not be negotiating rates with hospitals.[21]

- Self-pay and charity care discharges are paid a very small percent of the costs of care.

- Cost coverage for high-cost trauma care services is higher than cost coverage for high-cost non-trauma care services (99 percent and 91 percent respectively) (Appendix I, Table 5.4). Comparatively higher payments by car insurance companies for selected trauma discharges may influence this difference.

Of the 16 hospitals that submitted outpatient data, two hospitals accounted for almost 55 percent of the total number of outpatient services. Estimated cost coverage[22] for these outpatient services was 146 percent, corresponding to a 69 percent payment-to-charge ratio. The primary payor for these services was Medicare or private pay (Appendix K). Given the limited number of hospitals that submitted outpatient hospital data, however, care must be taken when drawing conclusions from this data.

[21] Lorenzen, C., Wyoming Medical Center, Telephone interviews (September and October, 2004).
Cussins, J., United Medical Center, Telephone interviews (September and October, 2004).

[22] As hospitals did not submit detailed charge information, we multiplied total charges for each claim by a hospital-specific cost-to-charge ratio developed from Worksheet C-II from hospitals' 2003 as-filed cost reports.

Transportation Services

An effective emergency medical response system relies on the knowledge of system resources and agency coordination to maintain a quick response and appropriate resource utilization. In addition, an effective emergency medical system requires safe, reliable ambulance transportation. Due in large part to its rural and frontier nature, Wyoming has fewer emergency medical service resources available to its population as compared to the nation (see Appendix I, Table 5.5). For example, air ambulance services are particularly limited; 25 percent of Wyoming's population has helicopter services available to it as compared to 75 percent nationwide.

Wyoming Medical Center is currently the only in-state facility offering full-time helicopter and fixed-wing aircraft transportation to patients,[23] although some individual physicians provide emergency air transportation on a volunteer basis using private planes in selected circumstances. There are nine flight services that are located out-of-state, however, that serve Wyoming residents. Wyoming residents use these services because of geographic proximity.

Local communities support in large part Wyoming ambulance agencies; [24] approximately 25 percent of all ambulance agencies in Wyoming do not charge for their services and receive little or no funding from their county governments. These agencies exist on monies raised from community fundraisers.

While the costs for hospital-based ambulance providers are present in the Wyoming Hospital Discharge Database, costs for free-standing ambulance providers are not. To better understand the provision of transportation service for trauma and catastrophic care patients, we analyzed data provided in the 2003 Ambulance Survey and the 2003 Wyoming Ambulance Trip Reporting System Database. These databases, however, do not contain estimated costs for ambulance providers or payments; therefore, it is not possible to add this information into the costs for the inpatient and outpatient hospital services (where those services are hospital-based).

Our analysis of the 2003 Ambulance Survey and the 2003 Wyoming Ambulance Trip Reporting System Database indicates that ambulance agencies may encounter difficulty obtaining payments for services rendered, and some of these agencies report high bad debt percentages. Many of these agencies supported by county funding do not bill for their services because of the administrative burden involved. Other agencies may have 100 percent of their charges reimbursed because they are under contract with a county hospital that is responsible for billing the patient.[25] Five ambulance agencies provide the majority of services in the state.[26]

[23] See Appendix F for the February 2004 Trauma Care Report provided by the Wyoming Health Care Commission (based on a Wyoming Medical Center Report).
[24] Cleveland, M., Wyoming Trauma Care Program, Telephone interview (October 2004).
[25] Mortimore, Clark, Mortimore Ambulance Services, Telephone interview (October 21, 2004).

Specifically:

- Sixteen percent of all ambulance providers are private agencies; 25 percent are governmental ambulance agencies (Appendix I, Figure 5.2).

- Twenty-five percent of the ambulance agencies do not charge for services and are either non-profit or governmental owned.[27] Some governmental-funded ambulance agencies will not charge for services because of the administrative burden involved in billing for the small number of services they provide. Some of these agencies receive their funding from county governments, which are also able to extend malpractice insurance to these agencies.

- In 2002, over 43 percent[28] of all ambulance services were staffed exclusively by volunteers. For the approximately one-half of providers that reported bad debt and percent of charges reimbursed, bad debt percentages ranged from 4 to 58 percent and 11 agencies had a bad debt percentage greater than or equal to 30 percent. In addition, two ambulance agencies, Pinedale – AMBTAC and Thermopolis, reported receiving payment for 100 percent of their charges and Pine Bluffs, Rawlins and Chugwater reported receiving payment for less than 50 percent of their charges (Appendix M).

- Two agencies provided the majority of trips to Wyoming patients (Cheyenne – American Medical Response and Casper – Wyoming Medical Center), for a total of 329,342 miles. These agencies received payments as a percentage of charges ranging from 55 percent (Cheyenne – American Medical Response) to 83 percent (Laramie FD). (Appendix I, Table 5.6 lists the top five ambulance agencies with the greatest number of trips.)

Ambulance Operating Budgets

Of the data reported (81 percent), the total operating budget for each organization varies between $1,000 and $9,200,000 and averages $539,622. Generally, governmental and private ambulance agencies have the highest operating budgets while most fire departments and community non-profit ambulance agencies have budgets less than $75,000 (Appendix M).

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[26] Wyoming 2003 Annual Ambulance Survey

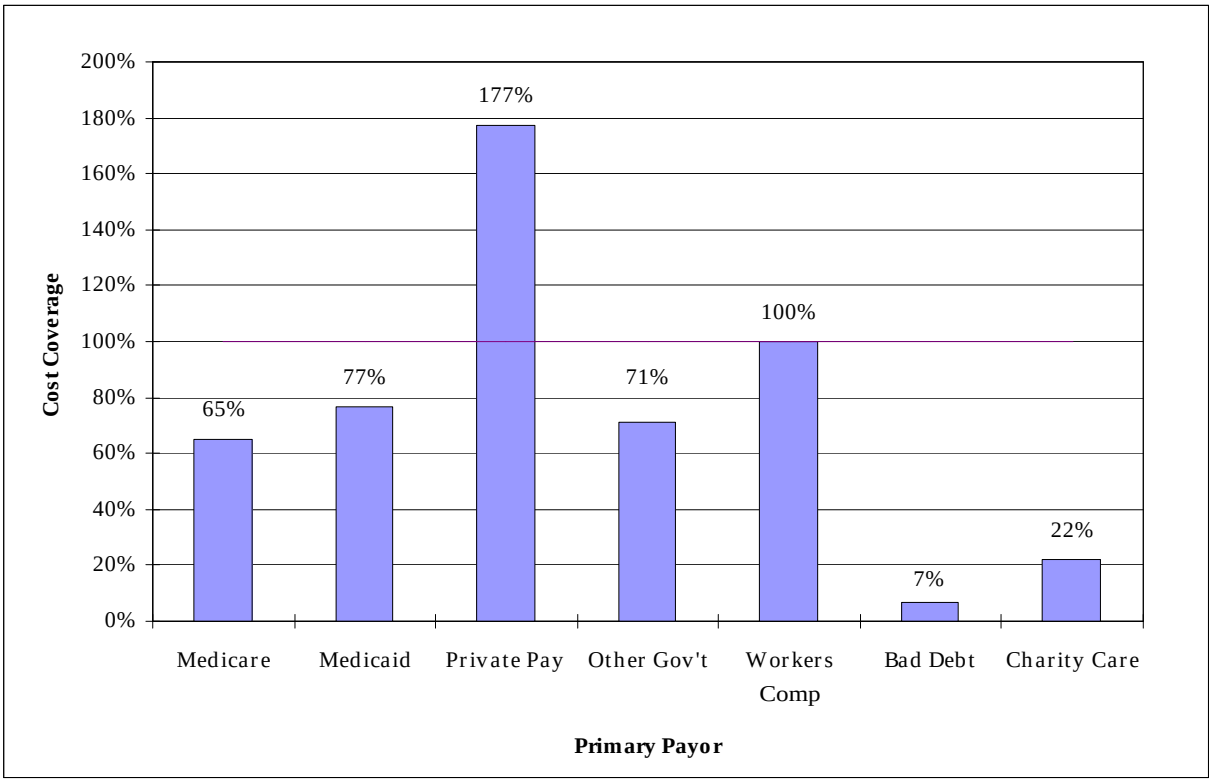
[27] Cleveland, M., Wyoming Trauma Care Program, Telephone interview (October 2004).

[28] Wyoming Office of Emergency Medical Services, Emergency Medical Services System Quick Stats, (2002). Available Online: http://wdhfs.state.wy.us/ems/Documents/Data/2002Quicstats.pdf.

Cost Shifting

To assess if there are unreimbursed catastrophic and trauma care costs that could potentially be shifted to private pay and private insurance companies, we analyzed cost coverage for the inpatient discharges in the Wyoming Hospital Survey. For the discharges reported for this Survey, trauma care cost coverage is 99 percent and catastrophic care cost coverage is 91 percent (Table 5.4 in Appendix I). This suggests that the uncompensated costs of trauma and other catastrophic care may be shifted to other payors. Figure V1.1 following shows different cost coverage levels of various payors for trauma discharges reported in the hospital survey and Figure VI.2 which follows shows different cost coverage levels of all discharges in the survey.

Figure V.1: Cost Coverage for Inpatient Trauma Discharges in the Hospital Survey, by Primary Payor, SFYs 2002 and 2003



Source: Catastrophic and Trauma Care Hospital Survey of Selected High Cost Discharges

Note 1: We identified the primary payor for each discharge as the payor with the most payments, considering a discharge with Medicare and Medicaid payments to be a dual eligible Medicare discharge. In some cases, there were minimal payments on a discharge even though the hospital indicated that the discharge was a bad debt or charity care discharge.

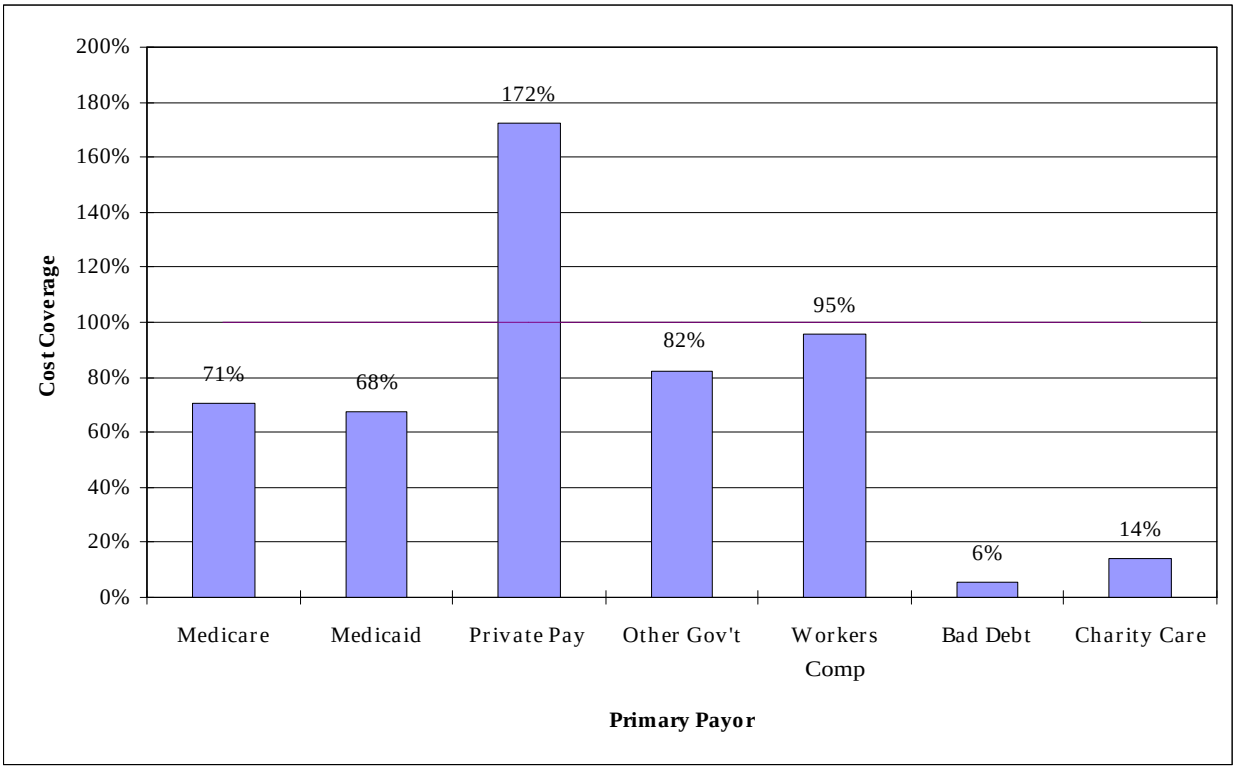
Note 2: Cost coverage represents payments of costs as defined by Medicare cost principles.

A study of potential cost-shifting in New Hampshire[29] suggested additional analyses of hospital finance that could be done to investigate whether cost-shifting occurs, including:

- How much cost-shifting is caused by higher than average cost structures?
- How much cost-shifting is caused by lower than average payments?
- How do charges and payments related to average cost for different procedures?
- What portion of gross charges are derived from which procedures and services?
- Which services and procedures generate the most excess revenues?
- Which service are "loss leaders?"

We agree that this information would be helpful to better understand potential cost-shifting and recommend that information presented in this section should be interpreted cautiously in the absence of additional hospital financial information.

Figure V.2: Cost Coverage for Inpatient Discharges in the Hospital Survey, by Primary Payor, SFYs 2002 and 2003



Source: Catastrophic and Trauma Care Hospital Survey of Selected High Cost Discharges

Note 1: We identified the primary payor for each discharge as the payor with the most payments, considering a discharge with Medicare and Medicaid payments to be a dual eligible Medicare discharge. In some cases, there were minimal payments on a discharge even though the hospital indicated that the discharge was a bad debt or charity care discharge.

Note 2: Cost coverage represents payments of costs as defined by Medicare cost principles.

[29] Hall, Douglass E., "Cost-Shifting in New Hampshire Hospitals" (October 2003) 17.

Summary

This section of the report has provided information about some financial issues related to hospital services in Wyoming. To summarize the most relevant findings:

- Inpatient and outpatient trauma care SFY 2004 costs total approximately $10.6 million,[30] $5.4 million of which is unreimbursed. Our study indicated, however, that hospitals have not consistently reported trauma care cases in the State's Trauma Registry, therefore, the number of trauma care cases may be significantly understated. Assuming that we have only one-fourth of the total trauma care discharges, we project that unreimbursed SFY 2004 trauma care costs could be $21.6 million.

- The average estimated cost per discharge for trauma care was over 35 percent higher than the average per discharge cost for all inpatient services (SFYs 2002 and 2003).[31]

- Inpatient SFY 2003 catastrophic care costs total approximately $32 million;[32] of the $31.7 million catastrophic costs that hospitals reported in the Wyoming hospital services, an estimated $4 million were unreimbursed. Our analysis of SFY 2003 outpatient hospital services submitted by hospitals for these discharges indicates that – in the aggregate – there were no overall unreimbursed outpatient hospital costs for catastrophic care. Given the limited number of hospitals that submitted outpatient hospital data, however, care must be taken when drawing conclusions from this data.

- Inpatient hospital costs for the uninsured totaled an estimated $15.8 million in SFY 2003.[33]

- Bad debt and charity care accounted for $66.3 million in SFY 2003, some of which is uncompensated trauma and catastrophic care.

- Some payors throughout the state reimburse at levels that are lower than costs.

- Most hospitals in Wyoming are small with relatively low census. Those low volumes do not give small hospitals opportunities to spread uncompensated costs to other patients.

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[30] From the Trauma Program Registry data; this data is incomplete and as it appears to represent one fourth of the trauma care provided in SFY 2004, we have annualized the $5.4 million to a total of $21,649,416.

[31] Wyoming Hospital Discharge Database as maintained by Solucient, State Fiscal Year 2003.

[32] Ibid.

[33] Represented estimated costs for discharges with a primary payor of "self-pay" or "medically indigent" from the Wyoming Hospital Discharge Database as maintained by Solucient, State Fiscal Year 2003.

- Hospitals, physicians and transportation services providers incur additional uncompensated trauma and catastrophic care costs. These costs include, for example, physician stipends, air ambulance standby capacity[34], administrative resources used for participation in the Trauma Program and trauma team activation charges.

- Two hospitals (Wyoming Medical Center and United Medical Center) provide the majority of hospital care in the state, as well as the greatest percentage of trauma and catastrophic care.

- Ambulance services in Wyoming are often provided on a volunteer basis or free of charge; at least 25 percent of all ambulance agencies do not charge for services and have no budget or have a token budget from a local government entity.[35] While small communities do not have enough volume to support an ambulance agency that bills for its services, a community effort is made to provide this service.

These and other factors suggest the financial stress that will continue to be placed on Wyoming hospitals. Unlike many other states, all hospitals are sole community providers.[36] If a Wyoming hospital fails, there is no other hospital to provide services.

These findings also point to the potential need for policymakers to address the differences in Wyoming hospitals. The small critical access hospitals that provide the fewest number of discharges and the lowest levels of trauma care, catastrophic care, charity care and bad debt face the most financial difficulty. However, it is the largest hospitals, with the greatest number of discharges and proportions of charity care and bad debt, that provide the greatest levels of trauma care and catastrophic care. These hospitals are also the strongest financially.

Approximately 49 percent of trauma care costs[37] and 93 percent of catastrophic care costs are paid by various payors, leaving uncompensated costs that may be shifted to payors. Hospitals ultimately receive payment for some of these costs, the lack of payment for some cases may cause them to shift resources away from other needed activities, such as improving service options, thereby influencing the level and quality of care in the state.

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[34] Standby capacity, which means that the air ambulance is available at all times, allows rapid access to care for trauma patients.

[35] Cleveland, M., Wyoming Trauma Care Program, Telephone interview (October 12, 2004).

[36] Sole community providers are located more than 35 miles from other like hospitals (or in a rural area) and meet selected other criteria according to 42 *Code of Federal Regulations*, 412.92 [Source: Wyoming Hospital Association: Wyoming Hospitals' 2002 Year Data].

[37] Calculated using Trauma Registry data.