OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
HEALTHCARE INFORMATION DIVISION
ACCOUNTING AND REPORTING SYSTEMS SECTION
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June 2003

To: Hospital Chief Financial Officers
and Other Interested Parties

Re: Hospital Technical Letter No. 10

This is the tenth in a series of Hospital Technical Letters developed by the Office of Statewide Health Planning and Development (OSHPD or Office) regarding our uniform accounting and reporting system requirements for California hospitals. The purpose of these letters is to provide timely information to assist you in meeting these requirements.

UPDATE ON PROPOSED CHANGES TO ACCOUNTING AND REPORTING REQUIREMENTS

In June 2002, the Office began developing a regulation package to update the *Accounting and Reporting Manual for California Hospitals* (Manual). Most of the proposed changes were to implement recommendations identified in a consultant's report required by SB 1973 (Statutes of 1998). After the required review by the California Health Planning and Data Advisory Commission in December, the Office determined that the proposed charity care changes required additional analysis to ensure that all concerns were addressed. In April 2003, a panel representing hospitals, collection agencies, credit reporting bureaus, and consumer credit counselors provided their views on various charity care scenarios to give the commissioners a broader understanding of the issues. Any changes to the Office's charity care requirements will be handled as a separate regulatory package.

The remaining changes, however, have been submitted to the Office of Administrative Law for approval. Once approved, an update to the Manual (Hospital Transmittal Letter No. 10) will be sent in late July or August. Below are highlights of the proposed changes that are currently in the process of being approved:

Proposed Changes to Accounting and Reporting System Requirements

- Expanded Section 1270 of the Manual to provide guidance on four Medi-Cal supplemental payment programs: Emergency Medical Services payments (SB 1255); Construction and Renovation funds (SB 1732); Graduate Medical Education payments (SB 391); and Outpatient Disproportionate Share funds (SB 1179). Unlike SB 855 DSH Payments, these four supplemental payments are to be offset against Medi-Cal Contractual Adjustments. Currently, this section only covers the Medi-Cal Disproportionate Share Payment Program (SB 855). (*Recommended in SB 1973 Report.)*

- Revised Section 2430 of the Manual to indicate that the Healthy Families program must be included in the Other Third Parties - Managed Care payer category. The Healthy Families program is a low-cost insurance program to children who do not have insurance and do not qualify for no-cost Medi-Cal.

- Updated capitalization requirements on fixed assets in Section 1122 of the Manual to be consistent with Medicare guidelines. Minimum increased from $500 to $5,000.

Proposed Changes to Hospital Annual Financial Disclosure Report

Changes to the annual disclosure report will become effective with report periods ending on and after June 30, 2004. This means that hospitals with a report period (fiscal year) beginning on or after July 1, 2003 must have reporting systems in place that meet the new requirements.

- Simplified the standard units of measure for several cost centers on Report Pages 4 and 18. We changed:
  - RVS units to procedures for Cardiology Services, Radiology-Diagnostic, Radiology-Therapeutic, Nuclear Medicine and Ultrasonography;
  - MRI minutes to procedures for Magnetic Resonance Imaging;
  - Respiratory Therapy treatments to Respiratory Therapy adjusted patient days;
  - 30" sessions to 15" sessions for Physical Therapy and Occupational Therapy;
  - Average number of hospital employees to paid hospital FTEs for General Accounting and Personnel; and
  - Average number of nursing service personnel to nursing service FTEs for Nursing Administration.
  (*Recommended in SB 1973 Report.)*

- Added Live Birth Data Summary to Report Page 4, Utilization Statistics. Hospitals will be required to report live natural births and Cesarean sections from all hospital locations, instead of just deliveries in Labor and Delivery.

- Reduced the number of service codes on Report Page 2, Services Inventory, from nine to four codes. (*Recommended in SB 1973 Report.)*

- Added three new data items to Report Page 0, General Information: 1) the hospital's web site address, 2) the report preparer's organization name, and 3) the report preparer's e-mail address. E-mail addresses will not be made available to the public.

If you have any questions on proposed changes, please contact Tim Pasco at (916) 323-1955.

HOSPITAL ANNUAL DISCLOSURE REPORTS - Report Periods Ended 6-30-03 to 6-29-04

There are no changes to the Office's Hospital Annual Disclosure Report for the next reporting cycle, which covers report periods ended June 30, 2003 through June 29, 2004. The Office will be sending a notice this month to all hospital Chief Financial Officers with a report period ended June 30, 2003, reminding them that their next annual report is due on or before October 31, 2003. Hospitals must still use Office-approved vendor software to prepare their report, which may be submitted on a 3.5" 1.44 Mb diskette or as an e-mail attachment.

At this time, the software vendors are in the process of obtaining the Office's approval to distribute software version 29a (hospitals are beginning the 29th disclosure cycle) for completing your Hospital Annual Disclosure Report. The approval process is typically completed in September. If your software vendor has not contacted you about an upgrade, you may wish to contact them at the number below.

Vendor	Contact Person	Phone Number
Health Financial Systems	Charles Briggs	(916) 686-8152
Hospital Management Services	Lanny Hawkinson	(714) 992-1525
KPMG	Cathie Kincheloe	(213) 955-8992

SUBMITTING DSH REVISIONS for 2002 HOSPITAL ANNUAL DISCLOSURE REPORTS

Hospitals that would like to submit DSH-related revisions to their 2002 Hospital Annual Disclosure Report are asked to observe the DSH revision due dates below. Your efforts in this area will help OSHPD process all revisions by the February 1, 2004 deadline.

- **For report periods ended between January 1 and June 30: Submit revisions by October 31, 2003.** For example, a Hospital Annual Disclosure Report with a report period ended June 30, 2002 must be revised by October 31, 2003, to be included in the February 1, 2004 database.

- **For report periods ended between July 1 and December 31: Submit revisions by December 31, 2003**. For example, a Hospital Annual Disclosure Report with a report period ended December 31, 2002 must be revised by December 31, 2003, to be included in the February 1, 2004 database.

For more information regarding policies and procedures for submitting revisions, please read Hospital Technical Letter No. 9 issued in July 2002.

QUARTERLY REPORTING IN 2003

All hospitals are required to use OSHPD's Internet Hospital Quarterly Reporting System (IHQRS) to prepare and submit their Quarterly Financial and Utilization Reports. The quarterly reporting periods and due dates for 2003 are:

Quarter	From	To	Due Date
1st Quarter	January 1, 2003	March 31, 2003	May 15, 2003 (Tue.)
2nd Quarter	April 1, 2003	June 30, 2003	August 14, 2003 (Thur.)
3rd Quarter	July 1, 2003	September 30, 2003	November 14, 2003 (Fri.)
4th Quarter	October 1, 2003	December 31, 2003	February 14, 2004 (Sat.)

Note: For the 4th quarter 2003 report, the due date of February 14, 2004 falls on a Saturday and the following Monday, February 16, 2004, is a holiday. This report may be submitted on Tuesday, February 17, 2004, and would not be considered delinquent.

iHQRS Enrollment and Electronic Certification Forms

It is important to keep the hospital's Report Preparer Profile current and secure. If the individual who prepared the previous quarter's report no longer works at the hospital, you should submit a new IQHRS Enrollment Form and change the User ID/Password combination. The iHQRS Enrollment Form is available at: www.oshpd.state.ca.us/ihqrs/

HINTS TO IMPROVE ACCURACY IN REPORTING

Medi-Cal Outpatient Lawsuit Settlement

Section 2410.5 of the Manual indicates that prior period contractual adjustments (or prior year cost settlements) are recorded and reported in Contractual Adjustments – Medi-Cal. The Manual does not make a distinction if prior year cost settlements are considered "normal and routine" for an individual hospital or if the settlement affects all hospitals from a long-standing lawsuit. As a result, hospitals are to record and report any lump-sum settlement resulting from this lawsuit as an offset (credit) to Contractual Adjustments – Medi-Cal in the period received. The 30% increase in on-going Medi-Cal outpatient reimbursements are to be treated in the same manner as standard Medi-Cal outpatient payments.

Tobacco Settlement Funds

As a result of the 1998 settlement between 46 states and the tobacco companies, California will receive approximately $1 billion annually over the next 25 years. The settlement monies will be split 50-50 between the State and local governments. Ten percent of the settlement will be allocated to four cities (that filed individual lawsuits), the remaining 40% will be divided between the 58 counties based on population. The tobacco settlement agreement placed no restrictions on the use of these funds.

The accounting and reporting of tobacco settlement funds will depend on how local governments elect to spend or allocate the funds. The table below provides some basic guidelines if tobacco settlement dollars are earmarked for hospital-related services and activities:

Use of Settlement Funds	Settlement Category	Account and Report As…
Restricted to offset specific expenditures (e.g., tobacco education and/or prevention, etc.)	Restricted Fund - Specific Purpose Fund (similar to a grant)	Other Operating Revenue – Transfer from Restricted Funds
Restricted for capital projects	Restricted Fund - Plant Replacement and Expansion Fund	Equity (Fund Balance) Transfer from Restricted Fund
Unrestricted use (non-county hospital)	Non-Operating Revenue	Unrestricted Contributions
Unrestricted use (county hospital)	Non-Operating Revenue	County Appropriations
Restricted to offset cost of providing care to indigent patients (most non-county hospitals)	Deduction from Revenue	Restricted Donations and Subsidies for Indigent Care
Restricted to offset cost of providing care to indigent patients (county hospitals and non-county hospitals with a contract to provide care to county indigent patients)	Deduction from Revenue	Offset (credit) to Contractual Adjustments – County Indigent Programs

Community Benefit Services Reported as Charity Care

In certain instances, services provided under a hospital's community benefit plan may be reported as charity care. To qualify, the services must meet the following criteria:

- the services are identified in the community benefit plan;
- the services are targeted at populations which would qualify for charity care as identified within the community benefit plan;
- the services are recorded a the hospital's full established rates (charges) as gross patient revenue;
- the services are provided by a licensed healthcare professional; and
- the services are those medical diagnostic or therapeutic services for which a medical record is generated or maintained.

Examples of qualifying services would include the operation of a satellite clinic or the provision of mammograms to uninsured, low-income patients. Services that would not qualify include free immunizations and health screenings provided to the general public at a health fair where no medical record was generated.

Cross-Reference From Nursing Cost Centers to Type of Inpatient Care

Report Page 4.1 (1) of the Hospital Annual Disclosure Report requires the reporting of patient days and discharges by type of inpatient care for each payer category. Table A is a cross-reference between the functional cost centers and the reportable types of inpatient care. Keep in mind that the total patient days on page 4.1, column 11 line 35 must agree with the total patient days on page 4, columns 4 and 5, line 150; and that the total discharges on page 4.1, column 22, line 35 must agree with the total discharges reported on page 4, column 12, line 150.

Table A – Cross-Reference From Nursing Cost Centers to Type of Inpatient Care

	Type of Inpatient Care					
Cost Center	**Acute**	**Psych.**	**Chem Dep.**	**Rehab.**	**L-T Care**	**Other**
Med/Surgical Intensive	X					
Coronary Care	X					
Pediatric Intensive	X					
Neonatal Intensive	X					
Psych Intensive		X				
Burn Care	X					
Other Intensive	X					
Definitive Observation	X					
Med/Surgical Acute	X					
Pediatric Acute	X					
Psych Acute – Adult		X				
Psych Acute – Adol & Child		X				
Obstetrics Acute	X					
Alternate Birthing Center	X					
Chemical Dependency			X			
Physical Rehab Care				X		
Hospice – Inpatient	X					
Other Acute Care	X					
Sub-Acute Care					X	
Sub-Acute Care – Pediatric					X	
Skilled Nursing Care					X	
Psych Long-Term Care		X				
Intermediate Care					X	
Residential Care						X
Other Long-Term Care					X	
Other Daily Hosp. Services						X

Cross-Reference From Outpatient Statistics to Type of Outpatient Visit

Report page 4.1 (2), lines 60 to 105, of the Hospital Annual Disclosure Report requires the reporting of outpatient statistics by type of outpatient visit for each payer category. Table B is a cross-reference which displays those outpatient statistics that must be combined and reported into a single type of outpatient visit. Those outpatient statistics that relate to a single type of outpatient visit are shown in Table C.

Table B – Multiple Outpatient Statistics Reported As One Type of Outpatient Visit

Outpatient Statistic	Type of Outpatient Visit			
	ER	Clinic	O/P Surgeries	Other
Emergency Services Visits	X			
Psychiatric ER Visits	X			
Clinic Visits		X		
Satellite Clinic Visits		X		
Satellite Amb. Surgery Ctr. Surgeries			X	
O/P Chemical Dependency Visits				X
Adult Day Health Care Days				X
O/P Surgery & Recovery Surgeries			X	
O/P Amb. Surgery Svcs. Surgeries			X	
Renal Dialysis Care Visits				X

Table C – Outpatient Statistics Reported As One Type of Outpatient Visit

Outpatient Statistic	Type of Outpatient Visit
Observation Care Days	Observation Care
Partial Hospitalization – Psychiatric Days	Psychiatric Day/Night Care
Home Health Care Service Visits	Home Health Care Services
Hospice – Outpatient Visits	Hospice – Outpatient
Referred Visits	Private Referred

Other Indigent vs. Other Payers

In Hospital Technical Letter No. 9, we mentioned that the Other Indigent payer category is to be used for reporting indigent patients that are not the responsibility of a county, and that charity care for the uninsured is to be reported here. Many hospitals continue to report the financial and utilization data for these patients (including charity care) as Other Payers, stating that it is very difficult to identify these patients at the time of service because a final charity care determination is often made several months after services were provided. Failure to identify these indigent patients may result in an understatement of uncompensated care services provided (if based on gross revenue or utilization).

We acknowledge that the processes of financial screening and application for government-sponsored coverage may take several months. One suggestion is to create a financial classification or insurance plan code named “Charity Care Pending” to record those patients whose eligibility for charity care cannot be made at the time of service. This is similar to the Medi-Cal Pending classification that some hospitals use. For reporting purposes, this gross revenue, related revenue deductions and utilization data for this classification/code could be reported under or split between Other Indigent and Other Payers based on the historical eligibility trends.

If you would like copies of previous Hospital Technical Letters, or if you have any questions, please call me at (916) 323-7681, or send a note to kkwong@oshpd.state.ca.us.

Sincerely,

Kenrick J. Kwong
Section Manager