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October 2006

To: Hospital Chief Financial Officers
and Other Interested Parties

Re: Hospital Technical Letter No. 16

This is the 16th 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.

NEW REQUIREMENTS: AB 774 HOSPITAL FAIR PRICING POLICIES

AB 774 (Chan, Chapter 755) was signed on September 29, 2006 and added Article 3 (commencing with Section 127400) to Chapter 2 of Part 2 of Division 107 to the California Health and Safety Code. General acute care hospitals will be required to implement a wide range of policies and procedures related to the provision of charity care effective January 1, 2007.

OSHPD Reporting Requirements

Per Section 127435, each general acute care hospital must provide OSHPD with a copy of the following documents:

- Charity care policy
- Discount payment policy (partial charity or sliding fee schedule)
- Eligibility procedures for these policies
- Review process
- Application form

The documents must be provided at least every other year on January 1, or when a significant change is made. If a hospital did not make a significant change since the information was previously provided, it may notify OSHPD of the lack of change to satisfy this requirement. OSHPD has the authority to require electronic submission and is required to make all information available to the public.

To implement AB 774, OSHPD plans to develop a web-based solution that allows for on-line submission and dissemination of the required documents. Regulations must be adopted to require electronic submission. One option is to require

submission of documents in a specified file format. Another alternative is to allow hospitals to submit policy information as text. Allowing time for developing the application and adopting regulations results in a projected commencement date for reporting of January 1, 2008.

It is suggested that each hospital carefully review the full text of AB 774 with respect to required eligibility, billing, and collection policies and procedures to ensure compliance by January 1, 2007. Questions related to implementation should be directed to your legal representatives, and not OSHPD. A copy of AB 774 is available at: http://www.leginfo.ca.gov/bilinfo.html

Key Business-Related Requirements:

Below is a summary of selected key business-related requirements based on OSHPD's interpretation of the statutes.

- Each general acute care hospital must comply with requirements as a condition of licensure, to be enforced by the State Department of Health Services. A hospital licensed as an acute psychiatric hospital, special hospital, psychiatric health facility, or chemical dependency recovery hospital is exempt from these requirements.

- Patients who are at or below 350 percent of the federal poverty level and are either uninsured or insured with high medical costs are eligible to apply for charity care. Any hospital may establish a higher eligibility level and those hospitals designated as "small and rural" may establish a lower eligibility level.

- Expected payment for eligible patients is limited to the amount received for similar services from Medicare, Medi-Cal, Healthy Families, or any other government-sponsored health program, whichever is greater.

- Each hospital must provide patients with a "language appropriate" written notice that contains information about the availability of charity care at the time services are provided and a written summary of the previously provided information when the patient is billed. According to Section 7296.2 of the Government Code, if 5% or more of the patients served are non-English speaking, then written correspondence must be provided to those patients in their primary language.

- Notice of the hospital's policy must be posted in visible public locations, including the emergency department, billing office, admissions office, and other outpatient settings.

- Each hospital must have a written policy about when and under whose authority patient debt is advanced for collection.

- Each hospital must establish a written policy defining standards and practices for debt collection, and must obtain a written agreement from an outside collection agency that it will follow the hospital's standards and practices.

- A hospital may not report adverse information to a consumer credit reporting agency or begin civil action against a patient during the first 150 days after initial billing. This requirement only applies to uninsured patients and to insured patients with high medical costs whose eligibility for charity care is in process of being determined.

- A hospital may not use wage garnishments or liens on primary residences to collect unpaid bills from patients eligible for full or partial charity care.

- A hospital must reimburse each patient for any amount paid in excess of the amount due under this statute, including interest.

UPDATE: PAYERS' BILL OF RIGHTS

The second reporting cycle for the Payer's Bill of Rights is nearly complete. We are pleased to announce that all but two hospitals (99.5%) have submitted the documents required by AB 1045 (Chapter 532, Statutes of 2005) and AB 1627 (Chapter 582, Statutes of 2003). Below are some of the common problems we encountered this year and how they were resolved.

Common 2006 Reporting Problems

1. Hospitals did not submit documents using file types specified in regulation (.xls or .csv). Hospitals that submitted the list of charges for 25 common outpatient procedures using an improper file type were required to re-submit the list. Comments and/or documentation related to the percentage change in gross revenue were accepted as text documents.

2. Hospitals used secured e-mail servers. While OSHPD understands the need for IT security, to obtain these files, OSHPD had to login to a secure site with a password within a specified time period to access the files. Due to the volume of submissions, establishing a login and password for each submission was not feasible. OSHPD requested these hospitals to re-submit documents as standard e-mail attachments or to mail documents on CD-ROM.

3. Submission did not identify the hospital or include contact information. In many cases, the e-mail cover message and/or submitted documents did not include the name of the hospital and/or contact information, making it very difficult for OSHPD to track submissions and/or contact the hospital. Since a $100 per day penalty may be levied for non-compliance, it is important that identifying information be included with your submission.

4. List of 25 common outpatient procedures included inpatient services. Some hospitals submitted the same list of services and procedures required by AB1627 with updated prices, and had to re-submit list to include only outpatient procedures.

5. The estimate of percentage change in gross revenue did not comply with statutory requirements. The most common problem was providing a percentage change in gross revenue, but not the required supporting documentation. This was particularly common when an "across-the-board" price increase was implemented, in which OSHPD requested information related to effective date and authority. Additionally, some hospitals were unaware of this AB 1627 reporting requirement and did not submit an estimate at all; while others submitted the average percentage price change for CDM items, rather than the percentage change in gross revenue due to these price changes.

Data Availability

OSHPD has updated its web-site to allow downloads of all documents submitted under the Payers' Bill of Rights. These documents are available at:
http://www.oshpd.ca.gov/HQAD/Hospital/Chargemaster/2005/chrgmstrA.htm

The table below summarizes the available documents:

Required Document	2005	2006
Chargemaster	Required by AB 1627	Required by AB 1627
List of 25 Commonly Charged Services or Procedures	Required by AB 1627	*Removed* by AB 1045
Estimated Percentage Change in Gross Revenue	Not Required	Required by AB 1627
List of 25 Common Outpatient Procedures	Not Required	*Added* by AB 1045

Almost all documents were submitted as Excel (.xls) files. In some instances, a Word (.doc) document was submitted and accepted. Most hospitals submitted separate Excel files; however, many elected to submit a single Excel file with multiple worksheets. Hospital comments that help explain reported information are included as Word documents.

If you are unable to download any document or would prefer to purchase a CD-ROM of all submitted documents ($10.00), please call OSHPD's Healthcare Information Resource Center at (916) 326-3802.

UPCOMING ANNUAL AND QUARTELRY REPORTING CYCLES

Annual Report Periods Ended 6-30-06 to 6-29-07

The reporting requirements for the 32nd year Hospital Annual Disclosure Report (HADR) cycle, which includes reporting periods ended June 30, 2006 through June 29, 2007, are the same as the previous year.

Effective September 21, 2006, the three software vendors below were approved to distribute HADR reporting software (Version 32A):

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

HADR Extension Policy: Hospitals may request 60 days on the initial HADR extension request. A second request must be submitted to use the remaining 30 days.

Quarterly Reporting for 2007

The reporting requirements for 2007 are the same as 2006. All hospitals are still required to use OSHPD's Internet Hospital Quarterly Reporting System (IHQRS) to prepare and submit their Quarterly Financial and Utilization Reports (QFUR). Quarterly Reports are due 45 days after the end of each calendar quarter.

Quarter	From	To	Due Date
1st Quarter	January 1, 2007	March 31, 2007	May 15, 2007 (Tue.)
2nd Quarter	April 1, 2007	June 30, 2007	August 14, 2007 (Tue.)
3rd Quarter	July 1, 2007	September 30, 2007	November 14, 2007 (Wed.)
4th Quarter	October 1, 2007	December 31, 2007	February 14, 2008 (Thu.)

QFUR Extension Policy: One 30-day extension will be granted upon request. The law prohibits OSHPD from granting more than 30 days.

HINTS TO IMPROVE DATA ACCURACY

Revised Guidance on Federal Section 1011 Payments

In Hospital Technical Letter No. 13 (May 2005), OSHPD indicated that Section 1011 patients should be reported in the Other Third Parties – Traditional payer category. This guidance was based on the premise that: 1) CMS was considered a third party payer; 2) that a Section 1011 payment was considered payment-in-full; and 3) that a contractual agreement would exist between the fiscal intermediary, hospital, and patient with respect to covered services and payment amounts.

Based on additional information about the Section 1011 Program, we have determined that the undocumented patients are considered uninsured since there is no contractual relationship between the hospital, CMS fiscal intermediary (Trailblazers Health Enterprises), and the patient. Consistent with current reporting requirements for uninsured patients, use of the Other Indigent and Other Payers category would be more appropriate.

The following guidelines apply equally to participating and non-participating hospitals since the financial status of the undocumented patient is the same at both locations.

The only difference is that participating hospitals, upon meeting certain criteria, are allowed to submit a claim to the Section 1011 Program for reimbursement. This methodology allows for transparency between the accounting and reporting of all uninsured patients, regardless of citizenship status.
It is expected that most undocumented patients, especially recent arrivals, will have little or no monetary assets. If an undocumented patient is determined to be unable to pay for services, the patient is classified as Other Indigent and reported in the Other Indigent payer category. The participating hospital may submit a claim to the Section 1011 Program for payment. Upon receipt of payment, the patient's accounts receivable is credited. The patient's accounts receivable would be further credited with any payments received resulting from balance billing efforts. The remaining unpaid accounts receivable would then be written-off to charity care.

Many undocumented patients, however, immigrated several years ago and have established themselves financially. If an undocumented patient is determined able to pay for services, the patient is classified as Self-Pay and reported in the Other Payers category. A Section 1011 payment received during the collection period would be credited against the patient's accounts receivable. That portion of the patient's accounts receivable that is determined to be uncollectible based on the patient's unwillingness to pay would be written-off to bad debts, net of any balance billed payments.

We do not believe that crediting Section 1011 payments to Restricted Donations and Subsides for Indigent Care is appropriate, because this would overstate the amount of uncompensated care (charity care and bad debts) actually provided. By crediting the patient's accounts receivable, the accounting for the receipt of Section 1011 payments is uniform for undocumented patients classified as either Other Indigent or Self-Pay, resulting in more data consistency and accuracy. Section 1011 payments are considered reimbursements for patient-specific claims and are not received as lump-sum subsidies or grants in the same manner as Tobacco Tax funds received by certain non-county hospitals.

Eligibility for Low-Income Government Programs and Charity Care

Several government programs exist to assist low-income patients, where eligibility requirements for such programs are clearly more restrictive than a hospital's charity care eligibility criteria. For patients enrolled in these programs, additional means testing is not necessary and the patient could be classified as Other Indigent with corresponding charity care write-offs. For example, the Breast and Cervical Cancer Treatment Program (BCCTP), Child Health and Disability Prevention Program (CHDPP), and Family PACT all use family income at or below 200% of the Federal Poverty Level (FPL) to determine eligibility. If a hospital uses a FPL threshold higher than 200%, then enrollment in these programs would provide sufficient justification that the patient also meets the hospital's charity care guidelines and that additional means testing is not warranted.

However, some government low-income programs do not rely solely on the FPL to determine eligibility. For example, eligibility to Access for Mothers and Infants (AIM) is

based on "household income" that falls between 200% and 300% of the FPL. The program identifies specific income deductions that are applied against gross monthly income to determine household income. Under the Genetically Handicapped Persons Program (GHPP), anyone with certain genetic diseases or medical conditions can enroll into GHPP. If a patient's adjusted gross income is above 200% of the FPL, an enrollment fee and some treatment costs must be paid by patient. In both of these programs, it appears likely that some enrolled patients may not qualify for hospital charity care and that financial screening is still required on a case-by-case basis.

In summary, if eligibility to a government low-income program is clearly more restrictive than the eligibility criteria specified in a hospital's charity care policy and the patient is enrolled in that program, then the hospital is not required to conduct additional financial screening for determining charity care eligibility. Since a patient's financial status may change over time, caution must be exercised to ensure that the patient is still qualified for the government low-income program at the time services are rendered. The hospital's charity care eligibility procedures should specify a reasonable time limit for using eligibility criteria from a government low-income program. For those programs where eligibility criteria is not as specific, eligibility for hospital charity care must still be determined on a case-by-case basis, even if that entails additional financial screening.

High-Deductible Health Plans and Charity Care Eligibility

There are several variations of the High-Deductible Health Plan (HDHP) where annual deductible amounts vary according to premiums paid. The objectives of the HDHP are to reduce healthcare costs by making patients more cost conscious when purchasing services, and to provide healthcare coverage to more individuals through affordable insurance premiums. Most HDHPs offer network and out-of-network services, with network services functioning similar to a Preferred Provider Organization (PPO). Some HDHPs are linked to Health Savings Accounts (HSA), where annual tax credits can be earned up to the amount of the HDHP deductible. Patients enrolled in a network-based HDHP should be classified in the Other Third Party – Managed Care payer category; otherwise, the Other Third Party – Traditional payer category should be used.

Deductible amounts are indexed annually to qualify as a HDHP and can range from $1,000 to $5,000 for individuals and usually double that amount for families, before health plan benefits are paid. Many plans established annual out-of-pocket individual/family maximums and lifetime maximum payments. Patient costs for hospital inpatient, outpatient and emergency services also vary with the patient typically responsible for a co-payment and a percentage of the billed charges. Out-of-network services are usually more costly to the patient.

Because HDHPs are being marketed to those in the lower income brackets, many of these patients may have family incomes that are below the FPL guidelines used by the hospital for charity care determination. Accordingly, if a HDHP patient is determined to be unable to pay for all or part of the deductible, co-payment or co-insurance; then that portion of the patient's accounts receivable may be written-off to charity care and reported in the appropriate Other Third Party payer category.

Home Office Costs

Most health systems include a "home office" or "parent company" that provides a wide range of administrative, general, and fiscal services for its subsidiary hospitals. As required by Section 1500 of the *Accounting and Reporting Manual for California Hospitals* (Manual), the cost of these services must be accounted for and reported in the appropriate functional cost center as a purchased service expense on the HADR, using natural expense classification .64 for management services and .69 for all other services. If home office costs are not identified separately and cannot be functionally reported on the HADR, report the entire amount as a purchased service in the Hospital Administration cost center (Account 8610) on page 18, column 6, line 205. Do not report home office costs on page 18, line 355 as Other Unassigned Costs (Account 8890) or on page 18, column 9 as Other Direct Expenses (natural classifications .77 to .90).

Exception: If the home office pays for unassigned costs such as professional malpractice or general liability insurance and/or interest on short-term/long-term borrowings, these costs should be functionally accounted for and reported in the appropriate Insurance (Accounts 8830/8840) and/or Interest (Accounts 8860/8870) cost centers as Other Direct Expenses on page 18, column 9.

Section 7020.15 of the Manual also requires that all services provided by a related organization be disclosed on page 3.1, lines 1 through 16, of the HADR, including the nature of the services, amounts, and the page-column-line references where the amounts are being reported. During OSHPD's routine desk audit, amounts reported on page 3.1 are reviewed and traced to page 18 to ensure compliance with the reporting requirements.

Patient Chargeable vs. Non-chargeable Supplies

During our desk audit of page 17 in the HADR, we compare the ratio of supplies reported in Surgery and Recovery (Account 7420) against the supplies reported in Medical Supplies Sold to Patients (Account 7470). In many instances, hospitals are reporting patient chargeable supplies in Surgery and Recovery, because this cost center is where the supplies are being used. Such hospitals are required to move the supply costs and related revenue to Medical Supplies Sold to Patients. In a few cases, the supply charges are bundled with the service charge for Surgery and Recovery and not billed separately. It is appropriate to report these supplies in Surgery and Recovery when this occurs.

Sections 1103.1 and 2420.3 (Cont. 5) of the Manual states that the revenue and cost of medical and surgical supplies that are separately charged to patients must be reported in the Medical Supplies Sold to Patients revenue/cost center, regardless of which cost center the supplies are used. If medical and surgical supplies are not separately charged to the patient, the cost of those medical supplies must be charged to the using cost center.

Other Operating vs. Non-operating Revenue
Hospitals are required to report Other Operating Revenue and Non-operating Revenue on their annual and quarterly financial reports. For some report preparers, the distinction between these two types of revenue is not always clear.

Other Operating Revenue (Accounts 5010 to 5790) represents revenue related to health care operations, but not from patient care services. The most common errors include reporting Gift Shop sales, rental income, and interest income as Other Operating Revenue. Examples of Other Operating Revenue include non-patient food sales, rebates and refunds, purchase discounts, supplies and drugs sold to non-patients, Medical Records abstract sales, and Reinsurance Recoveries. Other Operating Revenue is reported on Pages 8 and 14 of HADR and on line 810 of QFUR.

Non-operating Revenue (Accounts 9010 to 9400) includes revenue that does not relate directly to the provision of health care services. Examples of Non-operating Revenue include gains on the disposal of assets; interest income from investments; Medical Office Building rental revenue; revenue from Other Retail Operations (e.g., Gift Shop); and various governmental assessments, taxes (excluding income taxes), and appropriations. Non-operating revenue is reported on Page 8 of HADR and on line 840 of QFUR, net of non-operating expenses.

MEDICARE PAYMENT SHORTFALL AS A COMMUNITY BENEFIT

Since 1995, OSHPD has collected hospital community benefit plans from non-profit hospitals as required by SB 697 (Statutes of 1994). Health and Safety Code Section 127345 (c) (1) defines community benefits as:

> *Health care services, rendered to vulnerable populations, including, but not limited to, charity care and the unreimbursed cost of providing services to the uninsured, underinsured, and those eligible for Medi-Cal, Medicare, California Childrens Services Program, or county indigent programs.*

Recently, the Catholic Hospital Association (CHA) along with the Voluntary Hospitals of America (VHA) and the American Hospital Association (AHA) have agreed that the unreimbursed costs (payment shortfalls) associated with Medicare patients should no longer be reported as a community benefit. The exclusion of Medicare payment shortfalls as a community benefit is contrary to statutory requirements.

The primary reasons cited by the industry include:

- Medicare payment shortfalls for some hospitals may be associated with inefficiency, not underpayment.
- Medicare is one of the best payers in many communities and Medicare payments can be higher than for managed care payers.
- Serving Medicare patients is not a true, differentiating feature of not-for-profit health care.
- Hospitals will compete aggressively to attract Medicare patients, but not for Medi-

Cal and other low-income patients that may qualify for charity care.
- Excluding Medicare payment shortfalls would make the overall community benefit plans more credible.

Legislation is required to remove Medicare payment shortfalls from the statutory definition of a community benefit. Until this happens, hospitals may be unsure whether to exclude Medicare payment shortfalls consistent with industry practice, or to include Medicare payment shortfalls as required by state law. This dilemma is further complicated by the Internal Revenue Service, who is looking into non-profit healthcare organizations and the community benefits they provide with respect to maintaining their tax-exempt status.

Short-term Solution

Medicare payment shortfalls must be included for OSHPD reporting purposes. It is suggested, however, that hospitals report community benefits both with and without the Medicare payment shortfall. This can be accomplished by providing total quantifiable community benefits with the Medicare payment shortfall and a second total that excludes the Medicare payment shortfall. Reporting in this manner will allow hospitals to meet the needs of all users.

Copies of previous Hospital Technical Letters are available on the OSHPD web-site. If you have any accounting or reporting questions, please call Tim Pasco at (916) 323-1955, or me at (916) 323-7681.

Sincerely,

Kenrick J. Kwong
Section Manager