oshpd Office of Statewide Health Planning and Development

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August 2011

To: Hospital Chief Financial Officers
and Other Interested Parties

Re: Hospital Technical Letter No. 23

This is the 23rd 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.

Hospital Quality Assurance Fees and Payments

SB 90 Reporting Instructions – Further Clarification

There has been some confusion in regard to the reporting instructions contained in Hospital Technical Letter No. 22 for SB 90 Hospital Quality Assurance (QA) Fee Program. Due to the importance of accurately reporting all parts of the program, we are providing further clarification.

In order to recognize any of the components of the program as expenses or revenue; Quality Assurance (QA) Fees and Supplemental Medi-Cal Payments (fee-for-service (FFS) and managed care), all parts must have received approval from CMS. This means that you could not report QA Fees paid as Hospital Administration expense or FFS Supplemental Medi-Cal Payments as (credit) to Medi-Cal Traditional contractual adjustments until approval was given by CMS for all components. This would include approvals for the Federal waiver and state plan amendment, which is necessary to implement the quality assurance and fee-for-service payments, and a separate approval is needed for the managed care component.

The reason we are instructing hospitals to report transactions on the Balance Sheet until all CMS approvals are made is the bill includes "poison pill" language that would nullify the program if all CMS approvals have not been made. This means that even though QA Fees have already been paid and supplemental payments have been received, they would remain on the Balance Sheet in the event CMS approval is not made, in which case DHCS and hospitals must "refund" the amounts received. While this scenario is unlikely, it is a possibility and therefore, consistent with GAAP with respect to when revenue and expenses can be recognized.

Guidelines for accounting and reporting related transactions below will show how to report all components of the SB 90 QA Fee Program before and after all CMS approvals have been made:

BEFORE ALL CMS APPROVALS HAVE BEEN MADE

Quality Assurance Fees

QA Fees paid should be recorded and reported on the Balance Sheet as a Prepaid Expense (Account 1100).

Supplemental Payments

Two payment methods exist for supplemental Medi-Cal payments, one for FFS and another for managed care health plans. Supplemental payments should be recorded and reported on the Balance Sheet as Deferred Third-Party Income (Account 2120).

Summary of Reporting Requirements

The following table indicates where the amounts described above are to be reported on the Hospital Annual Financial Disclosure Report and the Hospital Quarterly Financial and Utilization Report **before all CMS approvals have been made**.

Hospital Fee Program	Annual Financial Disclosure Report	Quarterly Financial and Utilization Report
QA Fees	Page 5, column 1, line 50	Not reported
FFS Supplemental Payments	Page 5, column 3, line 70	Not reported
Health Plan Supplemental Payments	Page 5, column 3, line 70	Not reported

AFTER ALL CMS APPROVALS HAVE BEEN MADE

Quality Assurance Fees

Report QA Fees paid as an operating expense in Hospital Administration, Other Direct Expenses (Account 8610.90) in the reporting period in which CMS approval was made, not when actual QA Fees were paid to DHCS.

Supplemental Payments

Two payment methods exist for supplemental Medi-Cal payments, one for FFS and another for managed care health plans. In no instance should supplemental payments be netted against QA Fee expenses.

Report FFS supplemental payments as Medi-Cal Traditional net patient revenue via a reduction (credit) to Medi-Cal Traditional contractual adjustments (Account 5821) in the reporting period in which CMS approval was made, which may differ from when DHCS payments were received.

Managed care health plan supplemental payments are to be reported as Medi-Cal Managed Care net patient revenue via a reduction (credit) to Medi-Cal Managed Care contractual adjustments (Account 5822). Payment amounts and dates are not specified

in law, so it may be appropriate to recognize this revenue when payments are actually made.

Note: For some hospitals, the supplemental Medi-Cal payments may exceed the actual Medi-Cal contractual adjustments recorded for that reporting period, resulting in a negative (credit) balance. This is most likely to occur when completing the Quarterly Financial and Utilization Report for the calendar quarter ended September 30, 2011. In these instances, it is appropriate to report negative Medi-Cal contractual adjustments, in order for Medi-Cal net patient revenue to be correctly reported.

Summary of Reporting Requirements

The following table indicates where the amounts described above are to be reported on the Hospital Annual Financial Disclosure Report and the Hospital Quarterly Financial and Utilization Report **after all CMS approval has been made**. Other fields exist in the Annual Disclosure Report where the reported amount is automatically included in sub-totals and totals.

Hospital Fee Program	Annual Financial Disclosure Report	Quarterly Financial and Utilization Report
QA Fees	Page 18, column 9, line 205	Line 830
FFS Supplemental Payments	Page 8, column 1, line 315; Page 12, column 5, line 425	Lines 560 and 760
Health Plan Supplemental Payments	Page 8, column 1, line 320; Page 12, column 7, line 425	Lines 565 and 765

It is extremely important that each hospital strictly follow the above reporting requirements when submitting its Annual Financial Disclosure Report and Quarterly Financial and Utilization Reports. DHCS uses OSHPD annual financial data to determine eligibility for and payments amounts related to the Disproportionate Share Hospital program, and will use the OSHPD guidelines to make necessary data adjustments to its calculations under the assumption data are being properly reported.

Reporting Intergovernmental Transfers as Fund Balance Transfer

We consider all intergovernmental transfers to be fund balance transfers and should be reported on the Dispro. Share Funds Transferred to Public Entity line of the annual report, Page 7, column 1, line 105 and not as operating expense. This would also include intergovernmental transfers from Non-Disproportionate Share programs such as AB 113. We will be changing the account title from “Dispro. Share Funds Transferred to Public Entity” to “Intergovernmental Transfers to Public Entity” in a future Accounting and Reporting Manual update.

Quarterly vs. Annual Report review - Outpatient Visits

While performing our Quarterly Financial Utilization Report vs. Hospital Annual Disclosure Report review, we have noticed that many hospitals have large differences between outpatient visits on the Quarterly and Annual reports. The main reason given is that the outpatient visits are counted differently for Quarterly and Annual Reports. Per Section 4130 of OSHPD’s *Accounting and Reporting Manual for California Hospitals, Second Edition,* an Outpatient Visit is defined as 1) the appearance of an outpatient in

an ambulatory service center, or 2) the appearance of a private referred outpatient in the hospital for ancillary services. **Outpatient visits should be counted the same for both the Hospital Annual Disclosure Report and the Quarterly Financial and Utilization report; therefore, there should not be a variance between the two reports.**

New On-line Financial Reporting Program

OSHPD is in the process of developing an application that would allow facilities to submit annual financial disclosure reports on-line. The new application is called SIERA (System for Integrated Electronic Reporting and Auditing) and is expected to be released in the spring of 2012. Facilities would still continue to use third-party vendor software to prepare annual financial reports, but would submit the "transfer file" over the Internet instead of by email or on electronic media. Some of the features of SIERA include the ability to:

- Associate multiple users to a facility who are authorized to use SIERA
- Request an extension on-line and receive immediate confirmation
- Validate a report against OSHPD edits and make corrections before report is formally submitted
- Track the status of associated reports from pre-submission to completion
- Attach Certification and Transmittal Form

As we approach the SIERA release date, OSHPD will be contacting facilities to set-up the initial user accounts and associated facilities. The initial user accounts will be for report preparers who work at the facility or a related health system. These individuals will be authorized to grant access to external users, such as consultants, for their associated facilities. SIERA is being designed such that an external user can add another user to his/her associated facilities.

ANNUAL FINANCIAL DISCLOSURE REPORTING in 2011-12

The reporting requirements for the 37th year Hospital Annual Disclosure Report (HADR) cycle, which includes reporting periods ended June 30, 2011 through June 29, 2012, are the same as the previous year. The table below shows the current status of the software vendors who were approved last year. It is expected that KPMG will be also be approved to distribute HADR reporting software (Version 37A):

Vendor	Contact Person	Phone Number	Status
Health Financial Systems	Charles Briggs	(916) 686-8152	Approved
CDL Data Solutions, Inc.	Lanny Hawkinson	(714) 525-1907	Approved
KPMG	Joseph Quinn	(818) 227-6972	Pending

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 2012

The reporting requirements for 2012 are the same as 2011. 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.

2012 Quarterly Report Periods and Due Dates

Quarter	Period Begins:	Period Ends:	Date Due
1st Quarter	January 1, 2012	March 31, 2012	May 15, 2012 (Tue.)
2nd Quarter	April 1, 2012	June 30, 2012	August 14, 2012 (Tue.)
3rd Quarter	July 1, 2012	September 30, 2012	November 14, 2012 (Wed.)
4th Quarter	October 1, 2012	December 31, 2012	February 14, 2013 (Thu.)

*Note: Quarterly Reports due on a Saturday, Sunday, or State holiday may be submitted the next business day without penalty.

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

IHQRS Enrollment Form: If you are a new IHQRS user or want to change your User ID or Password, you must submit an IHQRS Enrollment Form. The User ID and Password must be five to 12 characters in length and are not case sensitive. Passwords must contain at least one alpha and one numeric character. Do not use any special characters (e.g., @, #, $ etc.). You can download the Enrollment Form from the IHQRS Home Page located at: http://ihqrs.oshpd.state.ca.us/

Copies of previous Hospital Technical Letters are available on the OSHPD web-site. If you have any accounting or reporting questions, please call me at (916) 326-3832.

Sincerely,

Original Signed By

Kyle Rowert
Hospital Unit Supervisor