OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
HEALTHCARE INFORMATION DIVISION
ACCOUNTING AND REPORTING SYSTEMS SECTION
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June 2001

To: Hospital Chief Financial Officers
and Other Interested Parties

Re: Hospital Technical Letter No. 8

This is the eighth 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 DATA REPORTING PROJECT

In 1998, SB 1973 was signed into legislation and required OSHPD to contract with a consulting firm to review the financial and utilization reports filed by hospitals with state government. The purpose of the bill was to:

- identify opportunities to eliminate the collection of data that no longer serve any significant purpose,
- to reduce the redundant reporting of similar data to different departments, and
- to consolidate reports wherever practical.

The consultant's review was expected to:

- result in greater efficiency in collecting and disseminating needed hospital information to the public, and
- reduce hospital costs and administrative burdens associated with reporting the information.

In April 1999, a contract was awarded to the consulting firm of Clark, Lowry & Koortbojian, who began work on the project in June 1999 and submitted its final report to OSHPD in December 1999. The final report contained 29 specific recommendations covering a wide range of topics, covering report consolidation, information dissemination, reporting issues, and the role of OSHPD. To obtain a copy of the full report, go to: http://www.oshpd.state.ca.us/hid/links/clark_lowry_koortbojian/clkrep.pdf

In July and November 2000, Office staff presented their findings and recommendations to the California Health Data and Public Information Committee, a sub-committee of the California Health Policy and Data Advisory Commission. Most of the consultant's recommendations will be fully or partially implemented. A brief summary of the recommendations and their status is attached.

Staff are in process of developing a regulation package which will incorporate some of these recommendations into the Office's uniform accounting and reporting system requirements. The proposed changes to the *Accounting and Reporting Manual for California Hospitals* (Manual) will most likely be distributed for public comment in late August. If you have any questions on proposed changes, please contact Tim Pasco at (916) 323-1955.

SUBMITTING REVISIONS TO HOSPITAL ANNUAL DISCLOSURE REPORTS

Each year, many hospitals submit revisions to their annual OSHPD disclosure reports in order to provide more accurate and reliable data. For hospitals that may qualify for the Department of Health

Services (DHS) Medi-Cal disproportionate share (DSH) program, the data must be submitted in a timely fashion in order to be included on the OSHPD database that is provided to DHS. To be utilized in the Medi-Cal DSH program, these data must be on file with OSHPD by February 1 each year according to Welfare and Institutions Code 14105 (f)(1)(d).

Almost 10% of the hospitals request to modify their OSHPD annual disclosure reports, which is a significant workload. Further, most hospitals are submitting their revisions during the last two weeks of January, which puts an additional strain on the Office's staff, who must accept, review and modify these corrected reports. The Office is sensitive to the hospitals' desires to provide the most accurate information available for both public disclosure and for Medi-Cal disproportionate share qualification purposes, and will continue to review, and if appropriate, correct all submitted revisions.

However, meeting the current February 1 mandated due date for Medi-Cal disproportionate share purposes is becoming more and more difficult. As a result, we are requesting hospitals to submit their revisions to their annual disclosure reports within one of two time periods. Although we will continue to evaluate changes to reports that are submitted outside of these time-frames, we cannot guarantee that the corrections will be made by the February 1 due date. The two due dates were developed to separate the two report periods (June 30 and December 31) which contain the most hospital reports. We request that hospitals submit their corrections as follows:

- **For report periods ended between January 1 and June 30: Submit all corrections by October 31.** This means that a Hospital Annual Disclosure Report with a report period ended June 30, 2000, must submit its revisions by October 31, 2001, to be included in the February 1, 2002 database.

- **For report periods ended between July 1 and December 31: Submit all corrections by January 15**. This means that a Hospital Annual Disclosure Report with a report period ended December 31, 2000, must submit its revisions by January 15, 2002, to be included in the February 1, 2002 database.

When submitting revisions to your annual disclosure report, be sure to clearly describe in a cover letter what changes you are requesting and why these changes are necessary. The cover letter must be signed by an individual who works for the facility or is authorized to submit revisions on the hospital's behalf. To reduce data entry errors, we request that the revisions be mailed and <u>not</u> faxed.

The Office does not have a prescribed format for revisions, other than corrected figures should be highlighted so that audit staff can easily follow the changes. Some hospitals will make the changes with their report preparation software and send the software-produced hardcopy reports with the changes highlighted, which is acceptable. If you made your changes using the report preparation software, do <u>not</u> send a revised data file to OSHPD. Others will send spreadsheets which correspond field-for-filed with the annual disclosure report.

We hope this is not an inconvenience, but it is a process that will enable OSHPD to better serve all of its users. If you have any questions on submitting revisions, please contact Tammi Salazar at (916) 323-7688.

<u>REMINDERS FOR SUBMITTING HOSPITAL ANNUAL DISCLOSURE REPORTS</u>

Hospital Annual Disclosure Reports are due four months after the end of a reporting period. If the due date falls on a Saturday, Sunday, or holiday, the report may be postmarked or delivered to the Office the next business day without penalty.

Penalties of $100 per day are assessed against hospitals that have not submitted their annual disclosure report or have not requested an extension and been granted an extension by the due date.

The Office may grant extensions, but not to exceed an accumulated total of 90 days, for all extensions and corrections. The policy of the Office is to grant a maximum of 60 days (in 30 day increments) for the extension of annual disclosure report due dates. The remaining 30 days are reserved in case the report must be returned for correction.

In certain instances, OSHPD may grant all 90 allowable extension days to submit a disclosure report. In the event the submitted disclosure report must be returned for corrections, a $100 per day penalty would be assessed beginning the day after the returned report was received by the report preparer.

All hospitals are required to prepare the OSHPD Hospital Annual Disclosure Report using Office-approved third-party software. Completed annual disclosure reports must be submitted on PC diskette. Two signed copies of the software-produced Transmittal and Certification must accompany the diskette. You do not need to send a software-produced hardcopy report. In some cases, completed annual disclosure reports may be sent to the Office as e-mail attachments.

Appendix C of the Manual covers each of these topics in great detail. If you have any other questions on submitting reports, please contact Patricia Burritt at (916) 323-0875.

MANAGED CARE AND NEW PAYER CATEGORIES DEFINED

Hospital Transmittal Letter No. 8 (October 1998) added several payer categories to the *Accounting and Reporting Manual for California Hospitals*. Besides establishing new payer categories for patients enrolled in managed care health plans, we also established an Other Indigent payer category. The Office has received numerous inquiries with respect to defining managed care, and the new and revised payer categories.

Managed Care – this term refers to more than capitated managed care contracts. It includes all patients who are enrolled in a managed care plan to receive health care through a panel of providers on a pre-negotiated or per diem basis, usually involving utilization review. Contracts between hospitals and health plans typically fall into these major categories: per diem contracts, risk sharing contracts, and capitated contracts.

Managed care health plans include Health Maintenance Organizations (HMO), Health Maintenance Organizations with Point-of-Service option (HMO-POS), Preferred Provider Organizations (PPO), Exclusive Provider Organizations (EPO), and Exclusive Provider Organizations with Point-of-Service option (EPO-POS). The term “managed care” is not restricted to those health plans licensed by the Department of Corporations under the Knox-Keene Health Care Service Plan Act of 1975. Because a managed care health plan may include members funded by Medicare, Medi-Cal, a county, employers, and private individuals, hospital accounting and reporting systems must be able to distinguish and track these payment sources for reporting purposes separately.

Capitation Premium Revenue – these are the gross capitated payments received (per member per month) by the hospital from a managed care health plan. It is not the gross charges related to patient care services provided to managed care patients at the hospital. Capitation premium revenue must not be reduced by the cost of patient care services purchased from another hospital.

If a health system or parent organization negotiates and receives the capitated payments directly from the managed care plan, an allocation of these payments must be made from the health system or parent organization to the facilities which are responsible for providing patient care services. The number of enrollees assigned to each facility would be a reasonable basis of allocation. Report these allocated amounts as Capitation Premium Revenue even though the hospital did not receive such payments directly from the managed care health plan.

Purchased Inpatient Services and Purchased Outpatient Services – these terms describe inpatient and outpatient services which are purchased by a contracting hospital from another hospital, typically arising due to managed care contract requirements or the lack of appropriate medical technology at the

purchasing hospital. The patients are formally admitted as inpatients or registered as outpatients by the facility providing the services.

If a health system or parent organization receives the capitated premium revenue and is also responsible for making payments for services purchased from other hospitals, an allocation of purchased service expenses must be made from the health system or parent organization to the facilities which are responsible for providing patient care services. The number of enrollees assigned to each facility would be a reasonable basis of allocation.

In both cases, the cost of services purchased from another hospital must be recorded and reported as a Purchased Inpatient or Outpatient Services expense, and not as a reduction (offset) to Capitation Premium Revenue.

Medicare - Traditional – includes patients formerly reported in the Medicare payer category, or those patients who are covered under the traditional Medicare fee-for-service program. These patients are primarily the aged and needy.

Medicare - Managed Care - this new payer category was formerly reported under Other Third Parties and includes patients covered by a managed care plan funded by Medicare. Examples include Blue Cross Senior Secure, Health Net Seniority Plus, PacificCare Secure Horizons, etc.

Medi-Cal - Traditional – includes patients formerly reported in the Medi-Cal payer category. Hospital reimbursements are either negotiated with the California Medical Assistance Commission or are cost-based, subject to certain limitations, and are paid through the Medi-Cal Fiscal Intermediary.

Medi-Cal - Managed Care - this new payer category includes patients covered by a managed care plan funded by Medi-Cal, and was formerly reported under Other Third Parties. Hospital reimbursements are made directly from the managed care health plan through the Two-Plan Model, County Organized Health Systems, or Geographic Managed Care.

Note: For those Medi-Cal DSH hospitals operating in a county where Medi-Cal Managed Care has been implemented, it is extremely important that these patients be properly identified, tracked, and reported, since your DSH eligibility and/or payment amounts may be affected. Contact the Department of Health Services' Medi-Cal Policy Division or your reimbursement specialists for more information.

County Indigent Programs - Traditional - this payer category includes patients formerly reported under the County Indigent Programs payer category, or those indigent patients covered under Welfare and Institution (W & I) Code Section 17000. Also included are patients paid for in whole or in part by the County Medical Services Program (CMSP), California Health Care for Indigent Program (CHIP or tobacco tax funds), and other funding sources whether or not a bill is rendered. This category also includes indigent patients who are provided care in county hospitals, or in certain non-county hospitals where no county-operated hospital exists, whether or not a bill is rendered.

County Indigent Programs - Managed Care - this is a new payer category for those indigent patients covered under W & I Code Section 17000, where indigent patients are covered by a managed care plan funded by a county. This payer category was formerly reported under Other Third Parties.

Other Third Parties - Traditional - this new payer category includes all other forms of third-party health coverage, excluding managed care health plans. Examples include Short-Doyle, CHAMPUS, California Children's Services, indemnity plans, fee-for-service plans, and Workers' Compensation. Also included in this payer category are patients from other health facilities which purchased patient care services from your hospital on behalf of their managed care patients.

Other Third Parties - Managed Care - this is a new payer category for those patients covered by managed care health plans other than those funded by Medicare, Medi-Cal, or a county. This includes managed care plans participating in the State's Healthy Families program.

Other Indigent - this new payer category includes indigent patients who are not the responsibility of a county W & I Code Section 17000 obligation, or those indigent patients who are not recorded in the County Indigent Programs category. Patients in this category are uninsured and often qualify in whole or in part for charity care services pursuant to the hospital's established charity care eligibility guidelines. This payer category was formerly reported under Other Payers.

Note: If your hospital is eligible for Medi-Cal DSH payments, you may want to consult with the Department of Health Service's Medi-Cal Policy Division or your reimbursement specialists to determine if and how the Other Indigent payer category may affect DSH eligibility or payment amounts.

Other Payers - this payer category includes uninsured patients who do not belong in the categories listed above, such as those designated as self-pay. As a result, most revenue deductions in this payer category are typically classified as bad debts.

We hope this helps clarify some of the terminology included in Hospital Transmittal Letter No. 8 and your 2000 Hospital Annual Disclosure Reports and Quarterly Financial and Utilization Reports. If you need additional assistance or clarification, please contact Tim Pasco at (916) 323-1955.

QUARTERLY REPORTING IN 2001

We are pleased to announce that 100% of the hospitals are using OSHPD's Internet Hospital Quarterly Reporting System (IHQRS) to prepare and submit their Quarterly Financial and Utilization Reports. Because of the overwhelming success of IHQRS, the Office is developing web-based applications to facilitate the preparation and submission of other OSHPD reports.

The quarterly reporting periods and due dates for 2001 are:

Quarter	From	To	Due Date
1st Quarter	January 1, 2001	March 31, 2001	May 15, 2001 (Tue.)
2nd Quarter	April 1, 2001	June 30, 2001	August 14, 2001 (Tue.)
3rd Quarter	July 1, 2001	September 30, 2001	November 14, 2001 (Wed.)
4th Quarter	October 1, 2001	December 31, 2001	February 14, 2002 (Thur.)

IHQRS Enrollment and Electronic Certification Forms

If the individual who prepared the previous quarter's report no longer works at the hospital or if you want to change your User ID and/or Password, you will need to submit a new IQHRS Enrollment Form. If the individual who signed the IHQRS Electronic Certification no longer works at the hospital, you must submit a new certification, Both enrollment and certification forms are located on the IHQRS web-site (www.oshpd.state.ca.us/ihqrs).

USEFUL TOOLS AND PRODUCTS ON OSHPD's WEB-SITE

The Office is continuing to develop its web-site, making more and more financial data products available to assist you in comparing your facility with other facilities. Some of our most popular data products include:

- Hospital Annual Financial Data Profile – this product is an Excel pivot table which includes a two-page profile of financial and statistical data derived from Hospital Annual Disclosure Reports. You can produce a profile for an individual hospital or all hospitals statewide. The pivot table allows you to customize your profile. For example, you can produce a profile of all non-profit, general acute care hospitals located in the County of Los Angeles with 200 to 299 licensed beds. Excel pivot tables are available for report periods ended 1995 through 1999.

- Selected Hospital Annual Financial Data – this popular download contains 225 selected data items derived from Hospital Annual Disclosure Reports and is available beginning with report periods ended July 1, 1996 through June 30, 1997. The data file is available in a comma-separated value text (TXT) format for MS Excel and database applications. Documentation in provided as a Portable Document Format (PDF) file.

- Hospital Quarterly Financial Data – this data product is derived from Quarterly Financial and Utilization Reports and is available for calendar quarters ended March 31, 1996 through December 31, 2000. For 2000 data, you can download either a data file for a specific quarter or an aggregated data file for all four calendar quarters. For 1996 through 1999 data, each download will give you the four individual calendar quarters and a year-to-date calendar year file. These data files are available in a comma-separated value (CSV) format.

- Hospital Quarterly Financial Reports – this web-based application allows you to view and/or print a Quarterly Financial and Utilization Report immediately after the report has been submitted to OSHPD. The output report contains data for the current quarter, the previous quarter, and the same quarter last year. Requestors will initially have access to a hospital's "submitted" report. After the completion of OSHPD's desk auditing process, the "audited" report becomes available. At this time, data are available from the first calendar quarter of 1997.

- Internet Hospital Profile Characteristics – this product is currently under construction and will be available shortly. It is our first attempt at developing an interactive web-based application which provides some of the flexibility of an Excel pivot table, while using “live” data from Quarterly Financial and Utilization Reports. Data users will be able to view and print profile reports for an individual hospital or for a user-defined aggregation for a single quarter or for four consecutive quarters.

- Hospital Accounting and Reporting Manual for California Hospitals – the entire Manual is located on the Office’s web-site with each chapter provided as a separate PDF file. Each report page from the Hospital Annual Disclosure Report and the Quarterly Financial and Utilization Report is also available as an Excel (XLS) file.

To find these products on the OSHPD web-site, click on **Healthcare Data Resources** from the Main Page. In the left margin, click on **Information Resources**, then **Hospitals**, and then **Financial**. To use these products, you will need WinZip to uncompress the data files and Adobe Acrobat Reader to view the Manual and data documentation. You will also need Microsoft Excel to use the pivot tables and to properly view and print the annual and quarterly reporting forms. If you are having trouble accessing or using these products, or have any suggestions or comments about the web-site, please contact our Healthcare Information Resource Center at (916) 326-3802.

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

OSHPD Hospital Data Reporting Project
Summary of Consultant's Recommendations

No.	Report Recommendation	Status
1.	Consolidate OSHPD Annual Utilization Report of Hospitals (AURH) with OSHPD Hosp9tal Annual Disclosure Report (HADR).	**Will not be implemented.** A streamlined AURH is being recommended for Internet-based reporting and data availability. PDD-related products will be created on a "request" basis.
2.	Consolidate DHS Medi-Cal Cost Report with HADR. OSHPD to collect reports and transmit Medi-Cal data to DHS.	**Analysis in process.** Need to establish Technical Workgroup to review legal and regulatory requirements, and auditing systems.
3.	Consolidate State Controller's Report with HADR.	**Will not be implemented.** OSHPD has no authority to collect SCO reports from the 28 hospital districts which are not licensed to operate a hospital.
4.	Make Page files of HADR available on the Internet and convert to SAS format.	**Partially implemented**. Pages 0-9 are available in a comma-delimited, text format.
5.	Change HADR cycle to RPE January 1 through December 31. (Current cycle: RPE June 30 y to June 29)	**Will not be implemented**. Would result in workload problems. OSHPD produces data products which are not affected by disclosure cycle.
6.	Establish uniform definition of charity care for reporting purposes.	**Analysis in process.** Possible State policy issue, since a uniform reporting definition means establishing uniform charity care eligibility criteria**.**
7.	Require Kaiser Hospitals to report payroll data for nursing personnel in routine cost centers (Page 21 of HADR).	**Will be implemented.** Will implement in 26th year (2000-01) disclosure cycle**.**
8.	Report total I/P ancillary charges by type of care and payer on HADR and QFUR. Purpose or reporting revenue is to determine full patient care costs.	**Will be partially implemented.** HADR will include I/P and O/P (?) ancillary charges by type of care. QFUR will not be changed at this time.
9.	Review and simplify standard units of measure on a case-by-case basis.	**Analysis in process.** OSHPD will survey hospitals to determine alternative units of measure for selected cost center.

OSHPD Hospital Data Reporting Project
Summary of Consultant's Recommendations

10.	Do NOT change current accounting and reporting requirements for services purchased from another hospital under capitated contracts.	**No action required.** HDPIC would like to discuss further in November 8, 2000 meeting.
11.	Consider elimination of uniform accounting requirements and mandate ONLY reporting requirements.	**Will not be implemented.** Accounting system is being used and OSHPD grants modifications to required chart of accounts.
12.	Terminate DHS contract to perform HADR/QFUR field audit and consider contracting with another State agency or accounting firm, or develop internal audit team.	**Analysis in process.** Possible State budget issue.
13.	OSHPD and CHPDAC should continue to enhance its role and mission re: facilitation of information usage.	**Implemented.** This is an on-going activity.
14.	Simplify codes on Services Inventory (Page 2 of HADR).	**Will be implemented.** Will implement in 28th year (2002-03) disclosure cycle**.**
15.	Combine OB, ABC, Nursery & L&D into a single reportable cost center when common nursing staff used.	**Analysis in process.** Need to determine if all hospitals should report on a combined basis, and if accounting system should be changed.
16.	Require hospitals to submit audited financial statements along with HADR, and provide copies when users purchase data. Eliminate Cash Flow Statement (Page 9 of HADR).	**Will not be implemented.** The cost of collecting, storing, copying, and providing hardcopy audited financial statements is not feasible.
17.	Report pediatric rehabilitation services in Rehabilitation Services rather than Pediatrics – Acute.	**Will be implemented.** Will implement in 28th year (2002-03) disclosure cycle**.**
18.	Evaluate joining Colorado DATABANK program (monthly reporting) in lieu of requiring QFUR.	**Will not be implemented.** Colorado is not interested in collecting DATABANK for other State departments.

OSHPD Hospital Data Reporting Project
Summary of Consultant's Recommendations

19.	Evaluate feasibility of requiring SB 697 Community Benefit Reports being submitted in a structured format and included as part of the HADR.	**Will not be implemented at this time.** OSHPD is developing standard community benefit formats and definitions. We will explore the consolidation of the Community Benefit Plans after initial implementation and refinements have been made.
20.	Modify HADR to capture information regarding hospital's charity care policy.	**Analysis in process.** We are collecting and reviewing hospital charity care policies to determine critical information.
21.	Clarify reporting of various Medi-Cal DSH programs. Describe how to use OSHPD data when DSH transfers to a related public entity are involved.	**Implemented**.
22.	Add indicator of CA Children's Service Neonatal Intensive Care certification level (Page 1 of HADR).	**Will be implemented.** Will implement in 28th year (2002-03) disclosure cycle**.**
23.	Continue producing hardcopy publications for HADR and QFUR.	**Will not be implemented.** OSHPD is developing web-based products to replace hardcopy publications.
24.	Improve input into OSHPD decision-making process. Suggestions include creation of a Data User Committee, and addition of a survey to web-site for data downloads.	**Implemented**. Focus Groups are being used.
25.	Add QFUR year-to-date files to web-site for each current quarter and prior year same quarter. Re-extract previously released QFUR files which would contain post-release revisions. .	**Will be implemented**. Will be implemented effective 4th quarter of 2000. Re-extraction will not be performed.
26.	Create a library of all published research studies using OSHPD data.	**Implemented**. Selected reports are available on OSHPD wen-site.

27.	Use descriptive column headings instead of field references on the AURH data files.	**Partially implemented.** Completed labels for hospitals, LTC facilities, and Primary Care Clinics. Labels for Specialty Care Clinics and Home Health Agencies will not be developed at this time.
28.	Include area-wide demographic data in HADR publications and the summary page of the HADR.	**Implemented.** Demographic information included in County Perspectives Project, but will not be available on HADR.
29.	Post a case-mix index file on web-site using patient discharge data.	**Implemented.** Downloadable case-mix index files are on the web**.**