oshpd Office of Statewide Health Planning and Development

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November 2010

To: Hospital Chief Financial Officers
and Other Interested Parties

Re: Hospital Technical Letter No. 21

This is the 21st 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

AB 1383 (Chapter 627, Statutes of 2009) established the Hospital Fee Program and became effective January 1, 2010. This year, AB 1653 (Chapter 218, Statutes of 2010), which included amendments requested by the Centers of Medicare and Medicaid Services (CMS), was signed into law. The legislation has three major components:

- Quality Assurance (QA) Fees paid by participating hospitals
- Supplemental Medi-Cal Payments paid to hospitals from the aggregated QA Fees and federal matching funds
- Direct Grants paid to Designated Public Hospitals

Assuming CMS approves of the health plan methodology, guidelines for accounting and reporting related transactions are as follows:

Quality Assurance Fees

Record and report QA Fees paid as an operating expense in Hospital Administration, Other Direct Expenses (Account 8610.90) in the calendar quarter ending December 31, 2010. Public hospitals, most small and rural hospitals, long-term care hospitals, and most specialty hospitals are exempt from paying the QA Fee.

Supplemental Payments

Two payment methods exist for supplemental Medi-Cal payments, one for fee-for-service (FFS) and another for managed care health plans. These guidelines also apply to supplemental payments received by Designated Public Hospitals for acute psychiatric

services. In no instance should supplemental payments be netted against QA Fee expenses.

Record and report FFS supplemental payments as Medi-Cal Traditional net patient revenue in the calendar quarter ending December 31, 2010; via a reduction (credit) to Medi-Cal Traditional contractual adjustments (Account 5821).

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 December 31, 2010. 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.

Direct Grants to Designated Public Hospitals

Only designated public hospitals will receive Direct Grants, which are classified as unrestricted grants because they do not contain donor-imposed restrictions. Record and report Direct Grants as non-operating revenue in Unrestricted Contributions (Account 9040) in the calendar quarter ending December 31, 2010. The legislation clearly states that Direct Grants do not constitute Medi-Cal payments. For county hospitals, this accounting and reporting treatment is consistent with GASB Statement No. 33, which classifies the Direct Grants as government-mandated, non-exchange transactions, which are typically not reported as operating revenue.

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. 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
Direct Grants	Page 8, column 1, line 510	Line 840

OSHPD Data Used

The QA Fees and supplemental payment amounts in the Hospital Fee Program were calculated based on Hospital Annual Financial Disclosure Reports with reporting periods ended in 2007, using data as of October 31, 2008. In this instance, the data and dates specified in legislation did not allow for the submission of revisions. This is another example where OSHPD data are being used to make important decisions with respect to funding healthcare services in California. As a consequence, it is extremely important that financial disclosure reports are carefully reviewed for accuracy prior to submission.

Further, it is important that each hospital strictly follow the above reporting requirements when submitting its Annual Financial Disclosure Report and Quarterly Financial and Utilization Reports. The Department of Health Care Services 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.

ANNUAL FINANCIAL DISCLOSURE REPORTING in 2010-11

The reporting requirements for the 36th year Hospital Annual Disclosure Report (HADR) cycle, which includes reporting periods ended June 30, 2010 through June 29, 2011, are the same as the previous year. OSHPD has approved the same vendors as last year to distribute HADR reporting software (Version 36A):

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	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 2011

The reporting requirements for 2011 are the same as 2010. 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.

2011 Quarterly Report Periods and Due Dates

Quarter	Period Begins:	Period Ends:	Date Due
1st Quarter	January 1, 2011	March 31, 2011	May 15, 2011 (Sun.)*
2nd Quarter	April 1, 2011	June 30, 2011	August 14, 2011 (Sun.)*
3rd Quarter	July 1, 2011	September 30, 2011	November 14, 2011 (Mon.)*
4th Quarter	October 1, 2011	December 31, 2011	February 14, 2012 (Tue.)

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/

NEW ON-LINE HOSPITAL FINANCIAL DATA PRODUCTS

Complete Data Set Available in Excel 2003 and 2007

OSHPD has developed a new Excel product that contains all hospital annual financial reports filed during a disclosure cycle in one Excel workbook. The Complete Hospital Annual Financial Data Set is available in both 2003 and 2007 Excel versions and can be downloaded from the following link: http://www.oshpd.ca.gov/HID/Products/Hospitals/AnnFinanData/CmpIteDataSet/index.asp for fiscal years from 2004 to current (2009). If you would like to order the Complete Hospital Annual Financial Data Set in Excel format on CD, please contact our Healthcare Information Resource Center at (916) 326-3802.

2009 Hospital Annual Financial Pivot Profile

The 2009 Hospital Annual Financial Pivot Profile is now available for download from the OSHPD website using the following link: http://www.oshpd.ca.gov/HID/Products/Hospitals/AnnFinanData/PivotProfles/default.asp

Hospital Annual Financial Disclosure Reports

Hospital annual financial disclosure reports (in .pdf format) from 2002 to present have been available on-line since October 2008. This site is updated daily, as reports are submitted and as desk audits are completed. If a report is in process of being desk audited, only the submitted report is available.

Detailed instructions and FAQs are located on the web-site, which can be accessed from the following link: www.oshpd.ca.gov/afpdfs

Hardcopy reports are still available for report periods ending before 2002 at a cost of $7.50 per hospital report and $6.00 per LTC facility report. If you have any questions about this site or want to order hardcopy reports, contact our Healthcare Information Resource Center at (916) 326-3802.

2nd Quarter 2010 Quarterly Report Profiles

Profile reports covering the 2nd Quarter of 2010 are now available for download from the OSHPD website using the following link: http://www.oshpd.ca.gov/hid/Products/Hospitals/QuatrlyFinanData/ProfleCharactrstcs/index.html. Just follow the online instructions to obtain Quarterly Profiles for individual hospitals or aggregate data using the selection criteria: Type of Hospital, Type of Control, Teaching or Small/Rural, and County.

Hospital Financial Performance Trends

The Hospital Financial Performance charts on the OSHPD website have been updated to include the 2nd Quarter of 2010. This chart shows the Operating Margin and Total Margin for all hospitals. Following the links will take you to five-year financial performance trends based on Annual Reports.

Since these charts are highly visible and derived from both Quarterly Reports and Annual Reports, it is imperative to make sure you report both reports as accurately as possible.

ACCOUNTING AND REPORTING GUIDELINES

Grant Accounting and Reporting

Restricted Grants

This is the most common type of grant, where the donor imposes restrictions on how the grant funds are to be used. Typically, the grantee (hospital) must apply for the grant, indicating the amount requested and its intended purpose. Grants can often be used to perform research, to provide education, to expand services or programs, or to purchase equipment. The grantor (donor) will review each application and if approved, will typically require the grantee to provide some form of accountability and/or follow-up to ensure that grant funds were used appropriately.

Upon receipt of the grant, a separate Restricted Fund (Report Page 6) should be established. When financial transactions occur which meet the grant conditions, matching funds can be transferred from the Restricted Fund to the Unrestricted Fund (Report Page 5) in the period that the restrictions are met. In some cases, the grant could be received and transferred within the same reporting period, resulting in the beginning and ending Restricted Fund Balances both being zero. On the Statement of Changes in Equity, report the grant in Restricted Contributions and Grants (Report Page 7, line 75, columns 2, 3, or 4).

If the grant covers operating expenses associated with specified services or programs, the grant is reported as Other Operating Revenue (Report Page 14) in Transfers from Restricted Funds for Research Expenses (Account 5010), Education Expenses (Account 5280), or Other Operating Expenses (Account 5790). These transfers will be used to offset operating expenses during the Cost Allocation process (Report Page 20a); and will also be reported on the Statement of Changes in Equity as Expenditures for Specific Purposes (Report Page 7, line 85, columns 2, 3 or 4).

If the grant covers the purchase of capital assets (e.g., equipment), funds are transferred from the Restricted Fund to the Unrestricted Fund Balance and are reported as an increase (credit) to Equity. Report such transfers between the Restricted Fund and Unrestricted Fund as Transfers for Property and Equipment Additions (Report Page 7, line 130).

See Section 1130 of the Manual for detailed information related to Restricted Funds.

Unrestricted Grants

If donor-imposed restrictions do not exist, report the grant as non-operating revenue in Unrestricted Contributions (Account 9040). The Direct Grants provided to Designated Public Hospitals under the Hospital Fee Program fall into this category.

Medi-Cal Short-Doyle

We have received several inquiries in regard to reporting Medi-Cal Short-Doyle patients, whether such patients should be reported as Medi-Cal or Other Third Parties. The following is a brief explanation of the program and the related reporting requirements.

In order to qualify for Medi-Cal Short-Doyle, Medi-Cal beneficiaries must obtain mental health services from hospitals that contract with a county mental health plan (MHP) and "waive freedom of choice". This means they can only seek mental health treatment from the MHP . The hospital bills the MHP, who pays the hospital a contract amount. The MHP then bills DMH to get the "Medi-Cal" portion of the payment. Lastly, DMH obtains partial reimbursement from the federal government. Since the MHP is making the payment to the hospital, Medi-Cal Short-Doyle should be reported as Other Third Party Traditional on the OSHPD hospital financial reports.

QUARTERLY VS. ANNUAL DATA COMPARISON

To ensure data quality and transparency, we are now comparing Quarterly Reports to Annual Reports during our Annual Report audit. Although this may result in additional questions, we feel this will help to enhance the data accuracy for both annual and quarterly reports. Please be sure to always revise your quarterly data when making material changes to the annual report.

AB 774 HOSPITAL FAIR PRICING POLICIES

AB 774 (Chan, Chapter 755, Statutes of 2006) required each hospital to submit its fair pricing policies to OSHPD using our web-based System for Fair Price Hospital Reporting (SyFPHR) beginning on January 1, 2008, and every other year thereafter. The next fair pricing policy reporting cycle will begin on **January 1, 2012**. The following information pertaining to AB 774 and the 2010-2011 fair pricing reporting cycle is provided to assist facilities as they review their current fair pricing policies to ensure compliance with the State law.

Significant Changes to Fair Pricing Policies

The law states that a revised fair pricing policy must be submitted whenever a significant change is made to any of the required documents. For the 2012 reporting cycle, if no significant change was made to the documents that were submitted in January 2010, you may notify OSHPD of this condition to meet the statutory requirements. As adopted in regulation, you must use still use the SyFPHR application to notify OSHPD that there has been no significant change.

NOTE: If the hospital's fair pricing policy specifies family income amounts relative to the Federal Poverty Guidelines, which change annually, then a revised submission is required.

Statewide AB 774 Data File Available

A statewide data file containing submitted information from the 2010-2011 fair pricing policy reporting cycle for each hospital is available at:

www.oshpd.ca.gov/HID/FairPricing/Fair_Pricing_Data_2010_Final.xls

AB 774 Informational Website

Information about AB 774 is available on the OSHPD website. You can obtain a copy of the statute, regulations, lists of exempt hospitals, FAQs, and more, at:

http://www.oshpd.ca.gov/HID/Products/Hospitals/FairPricing/index.html

AB 774 Common Reporting Problems Noted During 2010-2011 Review

OSHPD performs a review of each submission before the files are released to the public. Some of the common problems that were noted during the 2010-2011 review process include:

- Mismatch of the policy information entered on SYFPHR that was not in agreement with what was stated in the policies.
- There was not a clear, distinct separation between the four required documents.
- Some of the required documents were not submitted.
- The Federal Poverty Level (FPL) income level percentage was not clearly stated for patients that may qualify for free care.
- The discount percentages that were determined using sliding scales were not clear.
- Applications were imbedded within the policy files.
- Two policy files were submitted rather than one policy file and one application file.

2010 CHARGEMASTER AND RELATED PRICING INFORMATION

AB 1627 (Statutes of 2003) and AB 1045 (Statutes of 2005) established and amended, respectively, the Payers' Bill of Rights and requires each hospital to submit a copy of its chargemaster, the average charge for 25 common outpatient procedures, and the estimated percent change in gross revenue due to price changes every July 1.

Important Information Regarding the Submission of Supporting Documentation

The Office is responsible for verifying that the submitted documents meet the requirements of AB 1045 and AB 1627. Since the Office makes this information available to the general public on its Internet website, **it is the responsibility of hospital management to ensure that the documents submited to the Office do not contain any confidential/patient-level data. Specifically, do not submit any data containing a patient's name, social security number, phone number, address, e-mail or anything else that could be considered confidential in nature.**

The Office reviews all submitted documents for information that may be considered confidential, however, it is not feasible to search 100% of a submitted file for confidential information. For example, we will not perform a detailed search of files that may contain hidden worksheets, hidden data within a worksheet, or every cell in a worksheet.

The only supporting information that is required by AB 1045 and AB 1627 relates to the calculation of the Percentage Change in Gross Revenue due to Price Changes. We request that hospital management take steps to minimize the amount of additional information that is submitted. In the unlikely event that additional information is required to support the required documentation, it will be requested during the review process.

Beginning with the current 2010 Chargemaster reporting cycle and continuing forward, no supporting documentation other than that which is specifically required by AB 1045 will be excluded from the information that is distributed on the Office's website.

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