oshpd Office of Statewide Health Planning and Development

Accounting and Reporting Systems Section
400 R Street, Suite 250
Sacramento, California 95811-6213
(916) 326-3854
Fax (916) 323-7675
www.oshpd.ca.gov

July 2011

To: Hospital Chief Financial Officers
and Other Interested Parties

Re: Hospital Technical Letter No. 22

This is the 22nd 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

SB 90 (Chapter 19, Statutes of 2011) extended the Hospital Quality Assurance (QA) Fee Program for another six months, from January 1, 2011 to June 30, 2011. Full implementation of SB 90 is contingent on approval by Centers of Medicare and Medicaid Services (CMS), which has not been made as of July 1, 2011. The QA Fee program was originally established by AB 1383 (Chapter 627, Statutes of 2009) and amended by AB 1653 (Chapter 218, Statutes of 2010).

The legislation has two 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

Unlike the previous QA Fee program, SB 90 does not provide Direct Grants paid to Designated Public Hospitals or Medi-Cal supplemental payments to Non-Designated Public Hospitals.

Guidelines for accounting and reporting related transactions assume CMS approval is made during the calendar quarter ending September 30, 2011; and are as follows:

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 the Department of Health Care Services (DHCS). For most hospitals, QA Fees will be paid during the calendar quarter ended June 30, 2011; but recognized as expenses during the calendar quarter ending September 30, 2011. Until CMS approval is received, 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 fee-for-service (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 in the reporting period in which CMS approval was made, which may differ from when DHCS payments were received. For most hospitals, payments will be made during the calendar quarter ended June 30, 2011; but recognized as revenue during the calendar quarter ending September 30, 2011; via a reduction (credit) to Medi-Cal Traditional contractual adjustments (Account 5821). Until CMS approval is received, supplemental payments should be recorded and reported on the Balance Sheet as Deferred Third-Party Income (Account 2120).

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. 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. 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.

SB 335

SB 335 was introduced February 15, 2011 and would continue the Quality Assurance Fee Program for one year (July 1, 2011 to June 30, 2012). Similar to previous QA Fee legislation, SB 335 would use QA Fee revenue to draw down federal funds to provide Medi-Cal supplemental payments to private hospitals and for acute psychiatric days. Unlike SB 90, this bill would resume payment of Direct Grants to Designated Public Hospitals (county and University of California hospitals) in support of health care expenditures.

If this bill becomes law, OSHPD accounting and reporting requirements should remain basically the same, with the CMS approval date playing a significant role in determining when QA Fees, supplemental payments, and direct grants should be recognized and reported.

Comparison of Quarterly vs. Annual Reports – New Comparisons

One of the Office's data quality assurance activities involves the routine comparison of selected financial and utilization data from Hospital Annual Disclosure Reports (Annual Report) and corresponding Quarterly Financial and Utilization Reports (Quarterly Report). The goal is to provide data users with equal confidence in the accuracy of both data programs. Because Quarterly Reports are submitted over the Internet and viewable immediately after submission, the data are in high demand. Many data users appreciate the accessibility, timeliness, and simplicity of the Quarterly Reports.

For those hospitals whose annual reporting period ends on a calendar quarter (almost 95% meet this criteria), OSHPD would expect to find some differences because Quarterly Reports are due 45 days after the end of the calendar quarter while Annual Reports are due four months after the end of the fiscal year. However, in many instances, data users and OSHPD have observed very large differences between the two reports.

We have expanded our comparison to include the following data items for the 10 payer categories used by OSHPD:

New Comparisons by Payer Category:

Utilization Data: Patient Days, Discharges and Outpatient Visits.

Financial Data: Gross Patient Revenue and Contractual Adjustments.

Original Comparisons not by Payer Category:

Utilization Data: Licensed Beds.

Summary Income Statement Data: Capitation Premium Revenue, Other Operating Revenue, Total Operating Expenses, Net from Operations, Net Non-Operating Revenue, and Net Income.

Other Financial Data: Bad Debts, Charity – Other, SB 855 DSH Payments Received, and SB 855 DSH Payments Transferred.

The Comparison Report includes the above data from both reports and the differences are displayed as numbers and as percentages. Material differences are being sent by e-mail to the individual who prepared the Annual Report, along with contact information for the individual who prepared the Quarterly Report. Hospitals are being encouraged to carefully review material differences indicated on the Comparison Report and to submit necessary revisions. Failure to revise your reports will not result in any penalty, but may result in inaccurate findings and statements from those that use your reports.

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