oshpd Office of Statewide Health Planning and Development

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December 2012

To: Hospital Chief Financial Officers
and Other Interested Parties

Re: REVISED - Hospital Technical Letter No. 25

This is the 25th 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.

REVISED - SB 335 Reporting Instructions

Based on the new fee schedule from DHCS a few changes need to be made to reporting instructions given in this Technical Letter. For the 6/30/12 quarterly and annual reports ending 6/30/12, report the Quality Assurance (QA) fees paid for service periods 1-4. This amount should be reduced to only reflect the Fee-for-Service (FFS) portion since CMS has not given final approval for the managed care portion yet. Report the managed care portion of the QA Fee on the balance sheet as a prepaid expense until CMS gives final approval. Once CMS has given final approval for the managed care portion, recognize any accrued payments as expense, and report any subsequent managed care portion of the QA Fees and managed care payments in the service period payments are made. For the 5th service period, there is no longer a FFS QA fee due on 12/7/12 so you would not report a QA fee paid in the quarter ending 9/30/12. You would still report the FFS payment amount you were expected to receive in the 5th service period on 12/24/12. The dates for service periods 6-10 did not change but the QA fees paid were split between managed care and FFS. You would still report the FFS QA fees paid and FFS payments expected to be received based on the amounts listed in the new DHCS payment schedule shown at bottom of page 2.

A law enacted in 2011, SB 335 (Chapter 286, Statutes of 2011), extended the Hospital Quality Assurance Fee (QAF) Program to December 31, 2013. The Program had been set by AB 1383 (Chapter 627, Statutes of 2009) to originally end July 1, 2011.

In 2012, AB1467 (Chapter 23, Statutes of 2012) amended the law to allow for separate approvals by the U.S. Centers for Medicare and Medicaid Services (CMS) of FFS and managed care supplemental Medi-Cal Payments. Under AB 1383, the law did not allow hospitals to recognize QAF Program fees as an expense item or FFS payments as a revenue item until CMS approved both the FFS payments and the managed care

supplemental payments. The new law affects how some QAF Program data are to be reported to OSHPD: now, hospitals may recognize the QAF Program fees paid and FFS payments upon CMS approval only of the FFS payments; they no longer have to wait for CMS approval of both FFS and managed care supplemental Medi-Cal Payments prior to any accounting recognition.

Since the provisions of SB 335 (2011) cover more than one Fiscal Year, it is extremely important that each hospital recognizes the payments and fees paid in the same quarterly and annual reporting periods when submitting its Annual Financial Disclosure Report and Quarterly Financial and Utilization Reports. One reason for this is that Department of Health Care Services (DHCS) uses OSHPD annual financial data to determine eligibility for and payment 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. Also, many OSHPD data users rely on quarterly data since they are more recent than annual data and users may question the data validity unless they are consistently reported in each quarter.

Since CMS approval was given for the FFS portion on June 22, 2012, hospitals should recognize FFS payments and QAF Program fees in total retroactively for that Fiscal Year for the first four service quarters of the QAF Program from July 1, 2011 to June 30, 2012. For the remainder of SB 335, report FFS payments and QA fees paid in each of the next six corresponding service quarters (from September 30, 2012 to December 31, 2013) since CMS approval has already been given. **Please note that there would be no QA fee paid reported in service period 5 (OSHPD reporting period 9/30/12) since that was changed in the new fee service schedule from DHCS.**

The new revised DHCS payment schedule:

Service Period	QA Fee Due	FFS Payment	OSHPD Reporting Period
1	8/1/12	8/20/12	6/30/12
2	9/7/12	9/24/12	6/30/12
3	10/5/12	10/22/12	6/30/12
4	11/2/12	11/20/12	6/30/12
5	No Fee due 12/7/12	12/24/12	9/30/12
6	1/4/13	1/22/13	12/31/12
7	4/5/13	4/22/13	3/31/13
8	7/5/13	7/22/13	6/30/13
9	10/4/13	10/21/13	9/30/13
10	1/3/14	1/21/14	12/31/13
Managed Care 1	TBD	TBD	Cash basis in period fee/payment occurs
Managed Care 2	TBD	TBD	Cash basis in period fee/payment occurs
Managed Care 3	TBD	TBD	Cash basis in period fee/payment occurs

We are still instructing hospitals to report transactions on the Balance Sheet for the managed care supplemental Medi-Cal Payments until CMS approvals are made. Since managed care supplemental Medi-Cal Payments payment amounts and dates are not specified in law, it may be appropriate to recognize this revenue when payments are actually made once CMS approves the managed care portion.

In earlier years, the QAF Program did not include Direct Grants. Since 2011, the law resumes Direct Grants paid to Designated Public Hospitals and Non-Designated Public Hospitals in support of health care expenditures. Direct Grants are classified as unrestricted grants because they do not contain donor-imposed restrictions.

Summary of Reporting Requirements - before CMS approvals have been made

The following table indicates where to report QA Fee transactions on the Hospital Annual Financial Disclosure Report and the Hospital Quarterly Financial and Utilization Report before 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
Direct Grants	Page 5, column 3, line 75	Not reported

Summary of Reporting Requirements - after CMS approval has been made

The following table indicates where to report QA Fee transactions on the Hospital Annual Financial Disclosure Report and the Hospital Quarterly Financial and Utilization Report after 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
Direct Grants	Page 8, column 1, line 510	Line 840

AB 102 – 20% IGT Fee

AB 102 (Chapter 29, Statutes of 2011) authorized the Department of Health Care Services (DHCS) to assess a fee of 20% on each intergovernmental transaction (IGT) the state accepts to reimburse the department for the administrative costs associated with implementing these provisions and for the support of the Medi-Cal program. Since this is a fee related to administrative services, report the 20% IGT assessment fee under Hospital Administration, other, account 8610.90.

Hospital Value-Based Purchasing Program

The Hospital Value-Based Purchasing (VBP) Program was established by the Affordable Care Act of 2010 (ACA), which added Section 1886(o) to the Social Security Act. The Hospital VBP Program is a Centers for Medicare & Medicaid Services (CMS) initiative that rewards acute-care hospitals with incentive payments for the quality of care they provide to people with Medicare. Hospitals will start receiving bonus payments after October 1, 2012 if they provide high quality care or improve care based on a hospital's performance during the period from July 1, 2011 to March 31, 2012. Report any bonus received from the Hospital VBP Program as a credit to Medicare contractual adjustment since it is directly related to providing patient care services.

Rural Floor Settlement

The Centers of Medicare and Medicaid Services agreed to settle lawsuits due to Medicare underpayment of Diagnostic –Related Groups (DRGs) from 1998 to 2011 due to a math error and it is expected that about 200 California hospitals received this settlement. Report the Rural Floor Settlement as a credit to Medicare contractual adjustments since the settlement relates to underpayment of patient care services.

Charity Care reported in County Indigent Programs

Many hospitals are still reporting large amounts of charity care in County Indigent Programs (page 12, columns 9-12). The most common reason cited is the County ran out of money. According to Sections 7020.17 (Cont.1 and Cont. 2) and 8200 (Cont. 4) of the Hospital Manual, the County Indigent Program category is to include indigent patients who are the responsibility of the County under Welfare and Institution Code 17000, including those programs funded in whole or part by County Medical Services Program (CMSP), California Health Care for Indigents Program (CHIP) or Realignment Funds (or future State subsidy programs), regardless if the hospital renders to the County a bill or other claim for payment.

The primary revenue deduction in the County Indigent Programs payer category should be contractual adjustments, which is defined as the difference between the hospital's full established rates and the amount reimbursed. The only time there should be charity reported under the County Indigent Program is if the patient is responsible for part of their bill, such as co-pay. If the County runs out of money, the write-off is still considered a contractual adjustment.

If the patient does not meet the definition of a County Indigent Program patient as described above, does not have any other form of healthcare coverage, and qualifies for charity as defined in the hospital's charity care policy, then that patient should be reported as Other Indigent with the corresponding write-off to charity.

SIERA - NEW ON-LINE FINANCIAL REPORTING PROGRAM IS NOW LIVE

OSHPD's new application, SIERA (System for Integrated Electronic Reporting and Auditing), is now live. You are highly encouraged to use SIERA to complete the following tasks:

- Associate multiple users to a facility who are authorized to use SIERA

- Submit reports and request extensions 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

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 an attachment to an email or on a CDROM or other electronic media.

If you have not already done so, please:

- Set up a primary contact, an individual who is designated and responsible for receiving electronic correspondence and mail from OSHPD.

- Set-up initial user accounts and associated facilities if you have not already done so. These will be for report preparers at the facility or a related health system to authorize access to external users, such as consultants, for their associated facilities. SIERA is designed such that an external user can add another user to his/her associated facilities.

We are aware that some users are getting e-mails relating to report types they do not do, such as someone who only does annual reports may also get emails about quarterly report. We are working on a solution that would only send e-mails related to the report types you selected when setting up your user account in SIERA.

Hospitalist Reporting Instructions

The revenue and expenses associated with a hospitalist must be reported in the functional cost center(s) related to the care being provided. The revenue and expenses related to a hospitalist who sees patients in ICU, OB and Medical/Surgical Acute must be reported in those cost centers. This scenario assumes the hospital is separately billing for hospitalist services and recording professional fees. Another option is that hospitalist charges are included in routine room rates; in which case, the expenses must still be allocated accordingly.

Use of a single hospitalist account is acceptable for accounting purposes, as long as revenue and expenses are allocated to the using cost centers. While in most cases this would be a routine cost center, it could also apply to Ambulatory services as well, such as ER, Clinics, Observation Care, etc. To avoid year-end reclassifications, your accounting system may accommodate additional revenue and expense codes that would allow you to identify hospitalist revenue and expenses, while recording items directly to the functional cost centers.

If the hospitalist is employed by a medical group, we assume that all billing and expenses would be handled by the medical group. In these cases, there is no issue.

If the hospital contracts with a medical group that provides the hospitalist, then the same requirements apply as if working for the hospital. The medical group would need to provide information that would allow you to report revenue (if billed separately) and expenses by cost center.

ANNUAL FINANCIAL DISCLOSURE REPORTING in 2012-13

The reporting requirements for the 38th year Hospital Annual Disclosure Report (HADR) cycle, which includes reporting periods ended June 30, 2012 through June 29, 2013, are the same as the previous year. All vendors have been approved to distribute HADR reporting software (Version 38A):

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 2013

The reporting requirements for 2013 are the same as 2012. 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, 2013	March 31, 2013	May 15, 2013 (Wed.)
2nd Quarter	April 1, 2013	June 30, 2013	August 14, 2013 (Wed.)
3rd Quarter	July 1, 2013	September 30, 2013	November 14, 2013 (Thu.)
4th Quarter	October 1, 2013	December 31, 2013	February 14, 2014 (Fri.)

*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