HCAI Department of Health Care Access and Information
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November 2023

To: Long-Term Care Facility Financial
Personnel and Other Interested Parties

Re: EXPANSION OF PAYER CATEGORIES

HCAI's *Accounting and Reporting Manual for California Long-Term Care Facilities*, Second Edition (the Manual) is incorporated by reference in Section 97019 of the California Health & Safety Code. The Manual establishes the accounting system health facilities must use and details methods for completing and filing the required Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report (the LTC Report). Section 4001 of the Manual states that every skilled nursing and intermediate care facility required to be licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, Health and Safety Code, must complete and file this report.

To stay current with the LTC industry, HCAI has updated the payer categories that are collected and reported on the LTC Report *effective for report periods ending on or after January 1, 2024*. These reports are due four months after the end of the report period and, if requested, the due date can be extended an additional 90-days.

In June 2023, HCAI gave notice that we would be moving away from a single Managed Care payer category in Long-Term Care financial reporting. Medicare, Medi-Cal, and the new Commercial Coverage category will be broken down into Fee-for-Service or Managed Care in the chart of accounts. The regulations were filed with the Secretary of State on October 18, 2023 to be effective January 1, 2024.

The Manual update in it's entirety can be viewed on HCAI's website under Laws and Regulations, Expansion of Managed Care Payer Categories, Text of Proposed Regulations.

Chapters 1000, 2000, 3000, 4000 and Appendix B of the Manual have been updated to reflect these changes and can be accessed through HCAI's website. The following pages contain key excerpts from the Manual for accounting and reporting the new payer categories. Blank versions of the affected report forms (Pages 4.1 and 4.2 of the LTC Report) are included as attachments.

SUBCLASSIFICATIONS OF PATIENT SERVICE REVENUE ACCOUNTS AND DEDUCTIONS FROM REVENUE 2230

Decimal Point	Fifth Digit	Patient Classification Description	Sixth Digit	Financial Status Classification Description	Seventh Digit	Special Program Classification*
.	0	INPATIENT – FEE FOR SERVICE (Required)	0	SELF-PAY - (Required)	0	(Optional)
.	1	INPATIENT – MANAGED CARE (Required)	1	COMMERCIAL COVERAGE - (Required)	1	Sub-Acute Care
.	2	(Optional)	2		2	Sub-Acute Care - Pediatric
.	3	(Optional)	3	VETERANS ADMINISTRATION - (Optional)	3	Transitional Inpatient Care
.	4	OUTPATIENT – FEE FOR SERVICE (Required)	4	MEDICARE - (Required)	4	(Optional)
.	5	OUTPATIENT – MANAGED CARE (Required)	5	MEDI-CAL - (Required)	5	(Optional)
.	6	(Optional)	6	SHORT DOYLE - (Optional)	6	(Optional)
.	7	(Optional)	7	OTHER GOVERNMENT - (Optional)	7	(Optional)
.	8	(Optional)	8	CHARITY - (Required)	8	(Optional)
.	9	NON-PATIENT	9	OTHER PAYERS - (Required)	9	(Optional)

* The seventh-digit subclassifications for Sub-Acute Care, Sub-Acute Care - Pediatric, and Transitional Inpatient Care must be used by those facilities contracting with the Department of Health Care Services to provide these types of care.

SUBCLASSIFICATIONS OF PATIENT SERVICE REVENUE ACCOUNTS AND DEDUCTIONS FROM REVENUE 3230

The following provide definitions to the classifications shown in the chart in Section 2230.

Patient Financial Status Classification

Fifth Digit

.0X Inpatient Fee-for-Service – a patient who receives inpatient services and is enrolled in a coverage program that pays on a fee-for-service basis. Under fee-for-service programs, providers are reimbursed based on individual services provided.

.1X Inpatient Managed Care – a patient who receives inpatient services and is enrolled in a managed care plan. Under managed care, providers contract with health plans to deliver benefits in exchange for a monthly fee.

.4X Outpatient Fee-for-Service – a patient who receives outpatient services and is enrolled in a coverage program that pays on a fee-for-service basis. Under fee-for-service programs, providers are reimbursed based on individual services provided.

.5X Outpatient Managed Care – a patient who receives outpatient services and is enrolled in a managed care plan. Under managed care, providers contract with health plans to deliver benefits in exchange for a monthly fee.

Sixth Digit

.X0 Self-Pay - includes patients who are financially responsible for their own care and who are not covered by a third-party payer.

.X1 Commercial Coverage – These are patients who have private coverage that is employer/employment-sponsored or privately purchased. This includes Covered California plans. It does not include coverage funded by Medicare, Medi-Cal, a county, Workers' Compensation, or other government programs.

.X2 --

.X3 Veteran's Administration

.X4 Medicare - patients covered under the Medicare program. These patients are primarily seniors and people with disabilities.

.X5 Medi-Cal - a patient in this classification is one who is enrolled in Medi-Cal – California's Medicaid program for low-income people.

.X6 Short-Doyle - A state created program to offset the cost to the county for treating mentally ill patients who otherwise could not afford treatment and are not insured.

.X7 Other Governmental - patients covered by governmental programs not identified above.

.X8 Charity - See Section 1063.

.X9 Other Payers - all other financial classes not covered above, including patients covered by continuing care contracts. (Revenue for patients with a continuing care contract, but where the primary payer is one of the above payer classifications, should be recorded and reported by the primary payer.)

Page 4.1 - Facility Patient Days by Payer 4020.5

Enter in columns 1 through 8, the number of patient (census) days (including days for bedholds and leaves of absence) by payer and by routine services revenue center.

Count the day of admission, but not the day of discharge. Count as one, each patient admitted and discharged the same day. If a patient moves from one routine services cost center to another, actual patient (census) days for each routine service must be reported. If a patient changes one payer category to another during his or her stay, report patient (census days) by the primary payer for each day.

Where appropriate, payer categories should be further broken down to differentiate Fee-for-Service from Managed Care programs as defined below:

Fee-for-Service – beneficiaries can see any provider who accepted coverage, and providers are reimbursed for each individual service or visit.

Managed Care - under Managed Care, providers contract with health plans to deliver benefits to members in exchange for a monthly member fee.

Reporting Software for Report Periods Ending on or after January 1, 2024
The reporting requirements for the 48th year Long-Term Care Annual Financial Disclosure Report cycle have been revised to accommodate these updates. The approved software (Version 48A) is:

Health Financial Systems
Becky Dolin, President
(916) 226-6269
Becky.Dolin@hfssoft.com

The updated software should be available after the first of the year. To obtain an updated version of the reporting software, please contact Health Financial Systems. For blank copies of the reporting forms, please contact financial@hcai.ca.gov.

If you have questions regarding these new reporting requirements, please contact HCAI SIERA-Financial financial@hcai.ca.gov.

Respectfully,

A. Bloyd

Alexandra (Lexie) Bloyd, Supervisor
Department of Health Care Access and Information
Long-Term Care Financial Data Unit

Attachment: Report Form Pages 4.1 and 4.2

4.1

FACILITY PATIENT DAYS BY PAYER

Facility D.B.A. Name _____ Report Period End _____

Line No.	PATIENT (Census) DAYS	(1) Medicare Fee for Service	(2) Medicare Managed Care	(3) Medi-Cal Fee for Service	(4) Medi-Cal Managed Care	(5) Commercial Coverage Fee for Service	(6) Commercial Coverage Managed Care	(7) Self -Pay	(8) Other Payers	(9) Total (Cols. 1 - 8)
	Routine Services:									
5	Skilled Nursing Care									
10	Intermediate Care									
15	Mentally Disordered Care									
20	Developmentally Disabled Care									
25	Sub-Acute Care									
30	Sub-Acute Care - Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine Services									
70	Subtotal (Lines 5 through 45)									

4.1

4.2

FACILITY REVENUE INFORMATION

Facility D.B.A. Name _____ Report Period End _____

Line No.	GROSS REVENUE	Account Number	Medicare				Medi-Cal				Commercial Coverage				Line No.
			Fee for Service		Managed Care		Fee for Service		Managed Care		Fee for Service		Managed Care		
			(1) Inpatient .04	(2) Outpatient .44	(3) Inpatient .14	(4) Outpatient .54	(5) Inpatient .05	(6) Outpatient .45	(7) Inpatient .15	(8) Outpatient .55	(9) Inpatient .01	(10) Outpatient .41	(11) Inpatient .10	(12) Outpatient .50	
	Routine Services:														
5	Skilled Nursing Care	3100													5
10	Intermediate Care	3200													10
15	Mentally Disordered Care	3300													15
20	Developmentally Disabled Care	3400													20
25	Sub-Acute Care	3500													25
30	Sub-Acute Care - Pediatric	3520													30
35	Transitional Inpatient Care	3560													35
40	Hospice Inpatient Care	3600													40
45	Other Routine Services	3900													45
70	Subtotal (Lines 5 through 45)														70
	Ancillary Services:														
105	Patient Supplies	4100													105
110	Specialized Support Surfaces	4150													110
115	Physical Therapy	4200													115
120	Respiratory Therapy	4220													120
125	Occupational Therapy	4250													125
130	Speech Pathology	4280													130
135	Pharmacy	4300													135
140	Laboratory	4400													140
145	Home Health Services	4800													145
155	Other Ancillary Services	4900													155
170	Subtotal (Lines 105 through 155)														170
175	**Total Gross Revenue (Line 70 + 170)**														175

4.2 (1)

Line No.	DEDUCTIONS FROM REVENUE	Account Number	Medicare				Medi-Cal				Other Third Parties				Line No.
			Fee for Service		Managed Care		Fee for Service		Managed Care		Fee for Service		Managed Care		
			(1) Inpatient .04	(2) Outpatient .44	(3) Inpatient .14	(4) Outpatient .54	(5) Inpatient .05	(6) Outpatient .45	(7) Inpatient .15	(8) Outpatient .55	(9) Inpatient .01	(10) Outpatient .41	(11) Inpatient .10	(12) Outpatient .50	
205	Charity Adjustments	5100													205
210	Administrative Adjustments	5200													210
215	Contractual Adjustments - Medicare	5310													215
220	Contractual Adjustments - Medi-Cal	5320													220
222	Contractual Adjustments - Commercial Coverage	5330													222
225	Contractual Adjustments - Other	5340													225
230	Other Deductions from Revenue	5400													230
240	**Total Deductions from Revenue**														240
250	**Net Patient Revenue (line 175 - 240)**														250

4.2 FACILITY REVENUE INFORMATION

Facility D.B.A. Name _____ Report Period End _____

Line No.	GROSS REVENUE	Account Number	Self-Pay (13) Inpatient .00	Self-Pay (14) Outpatient .40	Other Payers (15) Inpatient .09	Other Payers (16) Outpatient .49	Total Gross Revenue (17) Inpatient (sum odd cols.)	Total Gross Revenue (18) Outpatient (sum even cols.)	Total Gross Revenue (19) Total (col. 17 + 18)	Line No.
	Routine Services:									
5	Skilled Nursing Care	3100								5
10	Intermediate Care	3200								10
15	Mentally Disordered Care	3300								15
20	Developmentally Disabled Care	3400								20
25	Sub-Acute Care	3500								25
30	Sub-Acute Care - Pediatric	3520								30
35	Transitional Inpatient Care	3560								35
40	Hospice Inpatient Care	3600								40
45	Other Routine Services	3900								45
70	Subtotal (Lines 5 through 45)									70
	Ancillary Services:									
105	Patient Supplies	4100								105
110	Specialized Support Surfaces	4150								110
115	Physical Therapy	4200								115
120	Respiratory Therapy	4220								120
125	Occupational Therapy	4250								125
130	Speech Pathology	4280								130
135	Pharmacy	4300								135
140	Laboratory	4400								140
145	Home Health Services	4800								145
155	Other Ancillary Services	4900								155
170	Subtotal (Lines 105 through 155)									170
175	**Total Gross Revenue (Line 70 + 170)**									175

Line No.	DEDUCTIONS FROM REVENUE	Account Number	Self-Pay (13) Inpatient .00	Self-Pay (14) Outpatient .40	Other Payers (15) Inpatient .09	Other Payers (16) Outpatient .49	Total Deductions from Revenue (17) Inpatient (sum odd cols.)	Total Deductions from Revenue (18) Outpatient (sum even cols.)	Total Deductions from Revenue (19) Total (col. 17 + 18)	Line No.
205	Charity Adjustments	5100								205
210	Administrative Adjustments	5200								210
215	Contractual Adjustments - Medicare	5310								215
220	Contractual Adjustments - Medi-Cal	5320								220
222	Contractual Adjustments - Commercial Coverage	5330								222
225	Contractual Adjustments - Other	5340								225
230	Other Deductions from Revenue	5400								230
240	**Total Deductions from Revenue**									240
250	**Net Patient Revenue (line 175 - 240)**									250