2010-11 Hospital Survey Frequently Asked Questions (FAQ)

This document is a compilation of a number of questions that have come up in the process of answering questions about the 2010-11 Hospital Survey which was mailed on March 16, 2010.

Updated: The descriptions on the survey refer to using the CMS 2552-96 cost report as a way to derive the figures. Please note that your patient census may be used to report your days data. Total days on your census should tie to total days on your cost report, within a small variance.

1. Q: Where are commercial payer (private insurance) days supposed to go?

   A: Numbers 1 (Managed Care days) and 2 (non-managed care days) are the fields where all private pay insurance days should be. Generally, facilities have a large majority of days in #1.

2. Q: Should #14 (Total Days) be the sum of numbers 1-13?

   A: The sum of 1 thru 13 does **not** necessarily sum to Total Days listed in number 14.

3. Q: Are the charges figures (#15, 16, 17) for inpatient charges only or inpatient and outpatient combined?

   A: The charges figures should be for both inpatient and outpatient combined.

4. Q: Should nursery days be included in items #1 (Managed Care days), 2 (non-managed care days), 10 (CICP days), 11 (Charity Care Days), 12 (Uninsured/Self Pay Days), and 13 (Other payer days)?

   A: Yes. Nursery days should be included in each of those lines.

5. Q: Should Medicare Rehab days be included in line 8 (Medicare fee-for-service days)?

   A: **Updated**: The Department had previously provided incorrect guidance on this FAQ. Under all categories, "day" means an inpatient hospital admission for at least twenty-four hours as reported on the hospital's patient census. Days related to swing-beds, long term care, nursing facility, home health, or residential treatment center cannot be reported. Inpatient days for rehabilitation and psychiatric care should be reported. This may include distinct part unit rehab or psych, or sub-acute rehab and psych, provided the patient has been in the hospital for at least 24 hours and is reported on the hospital's patient census.

6. Q: Should CHP+ days be counted in line 13 (Other payer days)?

   A: No, CHP+ is managed care, unless the client is in the pre-enrollment period. Please report normal CHP+ days in line 1.

7. Q: Should recoveries be netted out of line 16 (Bad Debt Charges, Excluding Medicare Bad Debt)?

   A: Yes. This number is analogous to what would be reported for the Bad Debt portion of worksheet S-10 of the cost report.

8. Q: Should days where CICP is a secondary payer (to private insurance for example) be counted in #10 (CICP days)?

   A: No. #10 should have those days where CICP is the primary payer.

9. Q: Can my facility report on our fiscal year basis though the survey is requesting data for calendar year 2008?

   A: We would rather have calendar year 2008, but if that is not feasible, report on your fiscal year 2008 and note so clearly.

10. Q: Please describe what the difference between #15 (Charity Care Write-Off Charges) and #17 (Uninsured/Self Pay Write Off Charges).

    A: **Updated**: For #15 we're looking for those charges where a patient qualified for some charity program (by some income measure for example) and those charges were written down on that basis. For example, if a service whose standard charge is $100 was changed to $40 for a patient who qualified for a "charity care" program, then $60 would be the amount to put in #15.

    Similarly for #17 we would like those charges that were written off for a person where there may have been some discount for paying cash, but does not qualify for a charity program.

Further clarification: For the upcoming FY 2010-11 hospital provider fee, non-CICP hospitals will be eligible for a Disproportionate Share Hospital (DSH) payment based on Charity Care write-offs. The purpose of asking for bad debt and uninsured/self-pay is to ensure that the charity care charges reported do not include bad debt or charges for clients who were self-pay but not receiving discounted or free services through the hospital's charity care program.

Bad debt can be derived from the bad debt component of the cost report worksheet S-10, line 30, less Medicare bad debt. Also, charity care charges can be taken from the charity care component of worksheet S-10, line 30; this should not include CICP charges.

Self-pay/uninsured write-off charges should be the revenue foregone, i.e., the amount discounted or adjusted for self-pay/uninsured clients. The description on the survey asks for the opposite. If you've reported self-pay/uninsured charges as described on the survey, no changes are required as those charges will not be the basis for any payments.

11. Q: Where should out-of-state Medicaid Days be reported?

    A: Out-of-state Medicaid days (a Medicaid client from a state besides Colorado), should be reported in the appropriate Medicaid category ("Medicaid Fee-for-service days" for example).