



# **Colorado Department of Health Care Policy and Financing**

## **Hospital Provider Fee Oversight and Advisory Board**

### **Cost Shift Data Work Group Recommendation Report**

**November 16, 2010**





## COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

November 9<sup>th</sup>, 2010

Mrs. Ellen Robinson, Chairman  
Hospital Provider Fee Oversight and Advisory Board

Madam Chair and members of the Oversight and Advisory Board:

The Department of Health Care Policy and Financing (The Department) was charged with convening the Cost Shift Data Work Group to submit recommendations to the Hospital Provider Fee Oversight and Advisory Board (OAB) regarding the data to be used to satisfy the statutory requirement found under Colorado Revised Statute 25.5-4-402.3 Section (6)(f)(V).

I would like to express the Department's sincere appreciation for the unwavering commitment, constructiveness, and diligence demonstrated by the members of the work group. Each member spent a considerable amount of time contributing their perspectives and expertise within a tight deadline. I want to also express the Department's appreciation to the Colorado Hospital Association (CHA) for its willingness to work as a partner to the Department, the OAB, and the Cost Shift Data Work Group as we worked toward this deliverable.

The issues that this work group was charged with addressing were difficult and at times extremely technical. Each member of this work group displayed astounding professionalism in tackling the challenges presented to them.

The attached report contains the recommendations of the Cost Shift Data Work Group to the OAB.

Sincerely,

A handwritten signature in cursive script that reads "Matt Haynes".

Matt Haynes, MPP, MA  
Cost Shift Data Work Group Facilitator  
Safety Net Financing Specialist, Department of Health Care Policy and Financing



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## **Work Group Composition**

The successful and timely completion, and the exceptional thoroughness and quality of this deliverable are directly attributable to the composition of this work group. The depth and breadth of expertise represented insured comprehensive and objective analysis, and the diverse representation provided confidence that the interests of a broad spectrum of stakeholders and interests would be considered during the process of making any and all decisions.

The following individuals served on the Cost Shift Data Work Group:

*(in alphabetical order by last name)*

- Erik Ammidown – Senior Director, Global Benefits, CH2M Hill
- Elisabeth Arenales – Health Care Program Director, Colorado Center on Law and Policy
- Jeff Bontrager – Senior Research Analyst, Colorado Health Institute
- Peg Burnette – Chief Financial Officer, Denver Health Medical Center
- Mary DeGroot – President, Colorado Women’s Health Alliance
- Jen Dunn – Critical Access Hospital Program Coordinator, Colorado Rural Health Center
- Matt Haynes – Financing Specialist, Colorado Department of Health Care Policy and Financing
- Tom Nash – Vice President of Financial Policy, Colorado Hospital Association
- Rick Newsome – Vice President and Chief Financial Officer, Kaiser Permanente of Colorado
- Jeff Orford – Provider Fee Analyst, Colorado Department of Health Care Policy and Financing
- Bob Semro – Health Care Policy Analyst, Bell Policy Center



## Executive Summary

On April 21, 2009, Governor Bill Ritter signed House Bill 09-1293, the Colorado Healthcare Affordability Act (the Act). By partnering with hospitals, the Act allows the state to assess a hospital provider fee to generate additional federal Medicaid matching funds to expand health care access, improve the quality of care for clients serviced by public health insurance programs, increase funding for hospital care for Medicaid and uninsured clients, and to reduce cost-shifting to private payers.

The Hospital Provider Fee Oversight and Advisory Board (OAB) is responsible for working with the Department of Health Care Policy and Financing (the Department) and the Medical Services Board (MSB) to develop the hospital provider fee model, monitor the implementation of the bill, help with preparation of annual reports on this program, and ensure that the Medicaid and Child Health Plan Plus (CHP+) eligibility expansions are implemented as intended.

The Department was charged with convening the Cost Shift Data Work Group to submit recommendations to the OAB regarding the data to be used to satisfy the reporting requirement found under Colorado Revised Statute 25.5-4-402.3 Section (6)(f)(V). The work group's recommendations are included in this report.

The approach to this project was developed from a commitment to a well understood scope of work and a set of guiding principles.

The scope of work is defined as:

*Determining, through due diligence and consideration, the data elements to be used to calculate the required payment to cost ratios, and documenting the justification for data recommendations.*

It is well understood that, despite the name of the work group, the scope of work does not involve measuring cost shifting.

The data needs to:

- a. Acceptably define the terms (e.g. "cost of care provided"),
- b. Be consistent over time,
- c. Be easily reported by hospitals,
- d. Be easily and securely collected from the hospitals,
- e. Be easily analyzed,
- f. Be conducive to analysis that will not be inherently complex and will be clearly understandable, and
- g. Be defined consistently across hospitals (to the extent possible).

This work group reviewed similar work from other projects and critiqued the data sources that were available. An important objective of this report is to document due diligence, explain the rationale for the recommendation, and disclose any caveats related to the recommended approach.

**The Cost Shift Data Work group makes the following recommendations to the OAB:**

Data

1. Utilize the Colorado Hospital Association (CHA) DATABANK as the primary data source.
2. The OAB should request from CHA a survey of DATABANK reporting of Bad Debt and Charity Care on an annual basis.
3. Collect Colorado Indigent Care Program (CICP) data from the Department's CICP Annual Report.

Methodology

4. Model the Following Payer Groups:
  - Medicare
  - Medicaid
  - Private Sector Insurance
  - CICP/Self Pay/Other
5. Follow the modeling methodology contained in Appendix A of this report.
6. Display CICP as a separate item.
7. Display Bad Debt and Charity Care as a supplemental item.
8. Report by State Fiscal Years. Begin with FY 2005-06.
9. Only include hospitals that receive Hospital Provider Fee payments.

While the work group believes that the recommended methodology is the most prudent given the data sources and options available, and that it is best aligned with the guiding principles, the recommended approach is not without limitations. It is important to be aware of the particular assumptions made under the recommended methodology. The recommended methodology produces *estimates* of the differences of the cost of care provided and the payments received by providers. The information resulting from the methodology is not intended to be an accurate reflection of hospital financial statements, but rather a measure by payer groups that is consistent and can be used to generate a representative trend over time.

## Background/Context

From the Blue Ribbon Commission for Health Care Reform's Final Report to the General Assembly dated January 31<sup>st</sup>, 2008:

*"[The Lewin Group's] analysis reveals that we all pay for the uninsured through the "cost shift." That is, when hospitals and other providers care for people without insurance who do not have the means to pay for their care, and when they care for enrollees in public programs (e.g., Medicaid, Child Health Plan Plus, etc.) at lower rates, providers must try to recoup the costs they have incurred by increasing the rates they negotiate with insurance companies. Insurers, in turn, pass those increases along to consumers in the form of higher premiums."(p.37)*

On April 21, 2009, Governor Bill Ritter signed House Bill 09-1293, the Colorado Healthcare Affordability Act (the Act). By partnering with hospitals, the Act allows the state to assess a hospital provider fee to generate additional federal Medicaid matching funds to expand health care access, improve the quality of care for clients serviced by public health insurance programs, increase funding for hospital care for Medicaid and uninsured clients, and to reduce cost-shifting to private payers.

A thirteen member Oversight and Advisory Board (OAB) appointed by the Governor provides oversight and makes recommendations to the Department and the MSB on the implementation of the Act.

The Department was charged with convening the Cost Shift Data Work Group to submit recommendations to the OAB regarding the data to be used to satisfy the statutory requirement found under Colorado Revised Statute (C.R.S.) 25.5-4-402.3 Section (6)(f)(V).

### Legislation –

Section 2 presents the Legislative Declaration of C.R.S. 25.5-4-402, and subparagraph IV states that a benefit of the statute is:

*(IV) Reducing the need of health care providers to shift the cost of providing uncompensated care to other payers.*

Section 6 of C.R.S. 25.5-4-402 creates the Oversight and Advisory Board (OAB), and subparagraph (f) explains:

*On or before January 15, 2010, and on or before January 15 each year thereafter, the advisory board shall submit a written report to the health and human services committees of the senate and the house of representatives, or any successor committees, the joint budget committee of the general assembly, the governor, and the state board. The report shall include, but need not be limited to:*

- (I) The recommendations made to the state board pursuant to this section;*
- (II) A description of the formula for how the provider fee is calculated and the process by which the provider fee is assessed and collected;*

*(III) An itemization of the total amount of the provider fee paid by each hospital and any projected revenue that each hospital is expected to receive due to:*

*(A) The increased reimbursements made pursuant to subparagraphs (I) and (II) of paragraph (b) of subsection (4) of this section and the quality incentive payments made pursuant to subparagraph (III) of paragraph (b) of subsection (4) of this section; and*

*(B) The increased eligibility described in subparagraphs (IV) and (V) of paragraph (b) of subsection (4) of this section;*

*(IV) An itemization of the costs incurred by the state department in implementing and administering the hospital provider fee; and*

*(V) Estimates of the differences between the cost of care provided and the payment received by hospitals on a per-patient basis, aggregated for all hospitals, for patients covered by each of the following:*

*(A) Medicaid;*

*(B) Medicare; and*

*(C) All other payers.*

## **Scope of Work and Guiding Principles**

The ideological approach to this project was developed from a commitment to a well understood scope of work and a set of guiding principles.

### Scope of Work

The scope of this project was shaped to a large extent by the legislative intent to reduce the need to cost shift created by payers that reimburse below costs, and the legislative reporting requirement. The scope of work is defined as:

*Determining, through due diligence and consideration, the data elements to be used to calculate the required payment to cost ratios, and documenting the justification for data recommendations.*

It is well understood that the scope of work does not involve determining the data necessary for measuring cost shifting.

### Guiding Principles

One of the first tasks of this work group was to identify the guiding principles that would be used to identify favorable data sources. Consensus was formed regarding the following set of principles. The data needs to:

- a. Acceptably define the terms (e.g. “cost of care provided”),
- b. Be consistent over time,
- c. Be easily reported by hospitals,
- d. Be easily and securely collected from the hospitals,
- e. Be easily analyzed,
- f. Be conducive to analysis that will not be inherently complex and will be clearly understandable, and
- g. Be defined consistently across hospitals (to the extent possible).

## Literature Review and Situation Analysis

The work group developed a practical approach to the situation analysis that would be directed by the scope of work and the guiding principles. There were three concrete steps:

- a. Investigate similar work done by other groups
- b. Investigate what data sources are available to use
- c. Attain a basic understanding of hospital cost accounting

### What Have Others Done?

While there is a plethora of academic research debating and analyzing cost-shifting, this work group was focused on state-level projects that calculated payment to cost ratios or utilized data similar to the data elements that the work group would be making decisions about. (e.g. charges, costs, payments, cost-to-charge ratio, data by payer group, etc.) The work group analyzed three different projects:

- CHA – Hospital Cost vs. Payment.
- Vermont Cost Shift Task Force Report to the Commission on Health Care Reform – Cost Shift Calculation Methodology
- Lewin Group/Arizona Chamber Foundation – Analysis of Cost Shift in Arizona – Data and Methods

### What Data sources?

It was important to identify the available sources of data and make judgments regarding the utility and acceptability of the data given the scope of work and the guiding principles. The data sources that the work group reviewed and considered were:

- CHA DATABANK
- American Hospital Association (AHA) – Annual Survey
- Medicaid Management Information System data using the Colorado Decision Support System
- Medicare/Medicaid Cost Report
- CICP reported data
- Thompson Reuters – MedStat
- Milliman
- Department generated survey
- Ingenix Hospital Benchmarks
- American Hospital Directory

### Hospital Cost Accounting

CHA was able to arrange a presentation of hospital cost accounting for the work group. The group felt that it was important to have some basic education in this area in order to answer a very basic question:

*Why aren't we just asking for the actual costs and payments from the providers instead of doing this calculation?*

Hospital Cost Accounting is not easy, is complex in nature, and is not consistent between providers. Inconsistency does not imply inaccuracy or incorrectness. The complexity, specificity, and distinctiveness of an

accounting system is important for a provider's performance and is all for a particular use. The cost accounting system for a particular hospital is designed to meet the specific needs of that particular hospital and is not intended to be aggregated with data from other providers. In other words, the peculiarity of cost accounting systems means that the internal records from hospitals will inherently be disparate. This makes it difficult to standardize and reliably aggregate the data. In addition, most providers do not calculate cost separately by payer group, but rather by patient since they do not charge differently by payer group. Patient accounts are charged the same regardless of their payer status. This basic understanding of hospital cost accounting contributed to the group's determination that the best available data source would be the CHA DATABANK and the best approach to arrive at costs would be the Cost-to-Charge Ratio.

# Recommendations and Methodology

## Data Recommendations

### **1. Utilize the Colorado Hospital Association (CHA) DATABANK as the primary data source.**

The CHA DATABANK Program is a web-based database of hospital utilization and financial performance indicators. There are approximately 63 hospitals reporting to the CHA DATABANK at any given time representing about 73% of CHA total membership. The reporting hospitals represent between 90-95% of the total licensed beds for the entire CHA membership. More information regarding the CHA DATABANK can be found at the CHA website at [www.cha.com](http://www.cha.com).

The Department will request data from the DATABANK that is aggregated to the state level.

- a. Hospitals report monthly\* to the DATABANK. We will collect data for:
  - i. Charges
  - ii. Contractual Allowances
  - iii. Bad Debt and Charity Care
  - iv. Expenses
  - v. Other Operating Revenue
  - vi. Discharges

*\*Some providers only report data once per year on a CY basis*

The DATABANK is not a perfect data source, and is not without limitations. The work group acknowledges that participation does not include every hospital in the state, some data is only reported in aggregate, and that there is some inconsistency in reporting.

Despite these issues, the work group believes that the benefits of utilizing the DATABANK, in terms of the scope of work and the guiding principles, outweighs the limitations and is the best available data source. The work group has made a recommendation concerning two data elements that are reported in aggregate: Bad Debt and Charity Care. This is addressed in the next recommendation.

### **2. The OAB should request from CHA a survey of DATABANK reporting of Bad Debt and Charity Care on an annual basis<sup>1</sup>.**

Bad Debt and Charity Care are only reported to DATABANK in aggregate. In order to allocate Bad Debt and Charity Care by payer group, the work group recommends surveying providers to solicit what percentages of Bad Debt and Charity Care are applicable to the respective payer groups.

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<sup>1</sup> Bad Debt and Charity Care are as reported in the CHA DATABANK as defined in Appendix B of this report. These definitions may not be identical to the definitions of these terms used in the calculation of Hospital Provider Fees and Supplemental Payments under the State Plan as approved by the Medical Services Board. Those definitions can be found in rule #: MSB 10-08-23-A.

**3. CICP charges and payments will be as reported in the CICP Annual Report.**

Data should be obtained from the CICP Annual Report year that corresponds with the Fiscal Year (FY) being modeled. Total charges, excluding physician, pharmacy and ambulance charges are historically found in financial Table 2A, and payments are found in Table 1.

Methodology

**4. Model the Following Payer Groups:**

- Medicare
- Medicaid
- Private Sector Insurance
- CICP/Self Pay/Other

These recommended payer groups differ from those stated in C.R.S. 25.5-4-402.3 Section (6)(f)(V). The work group recommends adding an additional payer group; “Private Sector Insurance”. This payer group would be comprised of commercial and managed care data from the DATABANK. As stated in the statute, the “All Other Payers” category would include private sector insurance along with uninsured categories. The work group operated under the premise that costs are shifted from the uninsured, underinsured, and publicly insured to private sector insurance payers. Therefore, it is best to not have the uninsured and private sector insurance as the same category. The work group recommends renaming the “All Other Payer” category “CICP/Self Pay/Other” in order to more accurately communicate what the new recommended category represents.

**5. Follow the modeling methodology contained in Appendix A of this report.**

Appendix A provides a detailed description of the modeling methodology. Below is a high level overview of the modeling methodology.

- i. Costs and Payments are derived from gross charges.
  1. Payments, or net revenues, are estimated by subtracting contractual allowances, bad debt, and charity care from gross charges.
    - a. The distribution of Bad Debt and Charity Care is determined by applying a weighted average to the survey results received from CHA.
  2. Costs are estimated by multiplying gross charges by the Cost to Charge ratio (CCR).
    - a. One average CCR is used for the modeling. Each payer group is calculated using the same CCR.

3. The Payment to Cost ratio is calculated by dividing the estimated payments by the estimated costs.
- ii. Per Patient estimates are derived using an estimate of combined inpatient and outpatient volume known as Adjusted Discharges.
  1. Discharges are converted to Adjusted Discharges by applying an adjustment factor equal to total charges divided by total Inpatient charges.
  2. The total payments minus costs are divided by the Adjusted Discharges to arrive at the payment relative to cost per patient.

**6. Display CICIP as a separate item.**

DATABANK does not ask for data for CICIP as a payer group, and reporting behaviors regarding CICIP are inconsistent among the providers. It is impractical to attempt to breakout CICIP as an additional payer group in the proposed methodology. However, the Department does have data concerning the charges and payments for the CICIP program. The work group believes that it is valuable to show the payment to cost estimates for CICIP as a supplemental item.

**7. Display Bad Debt and Charity Care as a supplemental item.**

Bad Debt and Charity Care are reported to DATABANK in aggregate and represent charges that have been written off as uncollectable or in accordance with the hospital's charity care policy. The CCR will be applied to these charges to show an estimated uncompensated cost number associated with the Bad Debt and Charity Care. The work group recommends including this as a supplemental item.

**8. Report by State Fiscal Years. Begin with FY 2005-06.**

The OAB Annual Report, as well as the Department's budgeting and rate setting, are each done on a State Fiscal Year basis. The work group recommends:

- i. Conduct calculations on a State Fiscal Year.
- ii. In order to have an historical trend leading up to the implementation of the Hospital Provider Fee, model beginning with FY 2005-06.
  1. Because Bad Debt and Charity Care allocation information was collected for the first time for the FY 2009-10 model, the allocation from that CHA DATABANK survey will be applied to all historical data.
- iii. The most current modeled year should correspond with the OAB Annual Report year.

**9. Only include hospitals that receive Hospital Provider Fee payments.**

Given that the intent is to measure the impact of the Hospital Provider Fee, the work group recommends that this modeling only be conducted for those providers receiving Provider Fee payments. There may be providers that were not in existence for all of the recommended historical data. The data for those providers will be included for the years that it is available.



## **Future Direction/Opportunities**

### New Data Sources

The Cost Shift Data Work Group suggests that the OAB remain informed of the emergence of new sources of like data. In the event that there is a new data source that better accommodates/fits the ideology and guiding principles that this work group has established, then it should be adopted.

The work group suggests that the OAB appropriately efforts to influence the development of future known potential data sources in order to work towards better meeting the values established by the work group. If the OAB is aware of the development of potential data sources, there should be some direction given to proactively influence, to the extent possible and acceptable, the development of that source to accommodate the data needs for the OAB reporting requirement under Section (6)(f)(V) of C.R.S. 25.5-4-402.

### National Health Care Reform

This report would not be complete without mentioning at least some of the potential effects of the Patient Protection and Affordable Care Act (ACA) on hospital reimbursement over the next several years. The ACA will introduce a number of variables that may affect the assessment of the impact of the Hospital Provider fee on the cost shift over time. These variables include a projected significant decrease in the number of uninsured and the resulting changes in payer mix and increased utilization that are the likely result of moving people from self pay into publically and privately insured status. There may also be changes in patient acuity levels, at least initially, as providers deal with pent up demand for medical care. The ACA requires reductions over time in Medicaid Disproportionate Hospital Share (DSH) payments to hospitals. Medicaid DSH is a significant source of CICP funding today although there may be reduced demand for the program as more people become insured. The ACA increases Medicaid and Medicare primary care provider rates which may impact some hospitals, particularly those with outpatient clinics. The ACA also increases reimbursement for certain rural hospitals. Finally, market basket and DSH reductions in Medicare payments required by the ACA may impact the cost shift calculation.

### Comment on Caseload Trends and Costs

While cost to payment ratios tell a part of the story, and total costs by payer group and net gains/losses to the system give some idea of volume of service, the work group suggests that the OAB consider tracking caseload and utilization trends after the implementation of the Provider Fee and its associated supplemental payments and expansion populations, and analyze the associated financial impact.

### Comment on Case-Mix

The work group suggests that consideration be given to incorporate case-mix by payer group into the methodology. The term case-mix refers to the type or mix of patients treated by a hospital or unit. The most common system used to classify hospital cases is the Diagnosis Related Groups (DRG).

The potential ability to arrive at case-mix from discharge and DRG data did not come to the attention of the work group until after the recommendations contained in this report were agreed upon, and the work group has not conducted any research or analysis into the matter at the time of this writing.

## Appendix A – Detailed Methodology

Payment to Cost Ratio Worksheet							
FY 2008-09 DATABANK Data							
Allocation of Charity Care		0.02%	0.62%	0.38%	98.99%	100.00%	
Allocation of Bad Debt		2.37%	1.60%	9.65%	86.38%	100.00%	
		Medicare	Medicaid	Private Sector Insurance	CICP/Self Pay/Other	Totals	CICP
Total Gross Charges		8,845,141,656	3,089,673,582	12,143,618,352	3,995,637,120	28,074,070,710	1,174,250,851
Contractual Allowances		6,674,857,412	2,500,650,576	6,301,712,839	1,180,782,759	16,658,003,586	
Charity Care		192,511	7,684,966	4,717,478	1,231,825,971	1,244,420,926	
Bad Debts		21,837,046	14,720,145	88,722,122	794,472,359	919,751,673	
Net Revenue (Payment)		2,148,254,686	566,617,895	5,748,465,913	788,556,031	9,251,894,525	175,692,774
Total Expenses	9,986,760,631						
Less Bad Debt	919,751,673						
=CCR Numerator	9,067,008,958						
Total Gross Charges	28,074,070,710						
Plus Other Operating Revenue	650,596,903						
=CCR Denominator	28,724,667,613						
Cost To Charge Ratio	0.316	0.316	0.316	0.316	0.316	0.316	0.316
Cost		2,791,989,788	975,262,740	3,833,161,722	1,261,232,264	8,861,646,514	370,655,046
Payment less Cost		(643,735,101)	(408,644,845)	1,915,304,190	(472,676,233)	390,248,011	(194,962,272)
Payment to cost ratio		0.769	0.581	1.500	0.625	1.044	0.474
Adjustment Factor		1.50	1.62	1.90	2.21	1.76	1.83
Discharges		144,782	64,162	163,290	92,937	465,171	19614
Adjusted Discharges		217,784	103,777	310,419	205,726	817,049	35916
Per Patient		(2,956)	(3,938)	6,170	(2,298)	478	(5,428)

### DATABANK Data

- Total Gross Charges – Gross charges are reported to DATABANK in aggregate and by payer group.
- Contractual Allowances – Contractual Allowances are reported to DATABANK in aggregate and by payer group.
- Charity Care – Charity Care is reported to DATABANK in aggregate
- Bad Debt – Bad Debt is reported to DATABANK in aggregate
- Total Expenses – Total expenses are reported to DATABANK in aggregate
- Other Operating Revenue – Other operating revenue is reported to DATABANK in aggregate
- Discharges – As reported by payer group
- Inpatient Charges – As reported in aggregate and by payer group
- Outpatient Charges – As reported in aggregate and by payer group

CICP Annual Report Data

- CICP Total Charges – Total Charges as found historically in Table 1 under CICP Financial Tables.
- CICP Payments – As reported historically in Table 1 under CICP Financial Tables

Calculations

*Allocation of Charity Care and Bad Debt*

Charity Care is allocated based on applying a weighted averaging to the survey responses collected by CHA. Providers are asked what percentage of their Charity Care they report in each payer category in DATABANK. Each respondent is given a weighting factor that equals the respondents total Charity Care as a percentage of the total Charity Care of all respondents to the survey question. Each given percentage response is multiplied by the weighting factor. The results are summed to determine a weighted average percentage of Charity Care for each payer group. Bad Debt is calculated in the same way except that the weighting is done relative to Bad Debt totals. Below is a snapshot of this calculation.

			Where are charges related to Charity Care reported in your DATABANK submission? Please indicate the percentages of Charity Care charges that are included in each of the DATABANK payer categories below (must sum 100%):								Weighted						
Charity Care per DATABANK	Percent of Total	Weight	Medicare Charges	Medicaid Charges	Self-pay Charges	Champus Charges	Managed Care Charges	Commercial Charges	Other Charges	Medicare Charges	Medicaid Charges	Self-pay Charges	Champus Charges	Managed Care Charges	Commercial Charges	Other Charges	
2,374,829	0.16%	0.33%			100					-	-	0.33	-	-	-	-	
2,199,117	0.15%	0.30%	0	0	0	0	0	0	100	-	-	-	-	-	-	0.30	
2,914,732	0.20%	0.40%			100					-	-	0.40	-	-	-	-	
5,346,705	0.37%	0.73%			100					-	-	0.73	-	-	-	-	
1,508,370	0.00%	0.00%								-	-	-	-	-	-	-	
105,639,884	0.00%	0.00%								-	-	-	-	-	-	-	
0	0.00%	0.00%								-	-	-	-	-	-	-	
1,251,792	0.09%	0.17%	9	5	50	0	10	26	0	0.02	0.01	0.09	-	0.02	0.04	-	
20,947,223	1.45%	2.88%			100					-	-	2.88	-	-	-	-	
9,931,617	0.69%	1.36%			100					-	-	1.36	-	-	-	-	
5,910,720	0.41%	0.81%							100	-	-	-	-	-	-	0.81	
55,634,047	3.84%	7.64%			100					-	-	7.64	-	-	-	-	
14,628,040	0.00%	0.00%								-	-	-	-	-	-	-	
2,310,110	0.16%	0.32%						100		-	-	-	-	-	0.32	-	
1,386,775	0.10%	0.19%							100	-	-	-	-	-	-	0.19	
44,347,942	3.06%	6.09%		10	90					-	0.61	5.48	-	-	-	-	
178,217,117	12.31%	24.47%	0	0	0	0	0	0	100	-	-	-	-	-	-	24.47	
281,974,456	19.48%	38.72%							100	-	-	-	-	-	-	38.72	
16,609,460	1.15%	2.28%			100					-	-	2.28	-	-	-	-	
92,796,996	6.41%	12.74%			100					-	-	12.74	-	-	-	-	
4,104,449	0.28%	0.56%							100	-	-	-	-	-	-	0.56	
1,447,461,633	50.31%	100.00%													Check	100.00	
									Totals	0.02	0.62	33.93	-	0.02	0.36	65.06	
																100.00	

*Net Revenue (Payment) and Costs*

Payments, or net revenues, are estimated by subtracting contractual allowances, bad debt, and charity care from gross charges.

Costs are calculated by multiplying total gross charges by the CCR.

### *Cost to Charge Ratio*

The numerator (the cost portion) for the CCR is calculated by subtracting total Bad Debt charges from total Expenses.

The denominator (the charges portion) for the CCR is calculated by adding Other Operating Revenue to total Gross Charges.

The CCR is calculated by dividing the calculated numerator by the calculated denominator.

### *Payment to Cost Ratio*

The payment to cost ratio is calculated by dividing calculated payments by calculated costs.

### *Adjustment Factor, Adjusted Discharges, and Net per Patient*

Discharges by payer group are converted to adjusted discharges by applying an adjustment factor. Adjusted Discharges serve as a proxy to represent total patients per payer group.

The adjustment factor is calculated by dividing total charges by total IP charges per payer group. Discharges are then multiplied by the adjustment factor to arrive at adjusted discharges.

The net gain or loss of payments less cost by payer group is divided by the adjusted discharges to arrive at a net per patient.

## **Appendix B – DATABANK definitions**

### **Colorado Hospital Association DATABANK Users Guide Excerpts**

#### **Payer Categories**

Utilization, charge information, contractual adjustments, and gross patient accounts receivable are reported separately for the following payer categories:

##### **Medicare**

Report all Medicare activity including fee for service and managed care/risk contracting.

##### **Medicaid**

Report all Medicaid activity including fee for service and managed care/risk contracting.

##### **Self Pay**

This category represents patients with no proof of insurance, patients filing their own insurance claims, patients paying their own bill, Hill-Burton cases, charity cases, etc.

##### **Champus**

Report activity for patients insured by the Civilian Health and Medical Program for the Uniformed Services including managed care for this population.

##### **Managed Care**

(a.k.a. "commercial" managed care): Include HMO, PPO, and direct contracting where the patient is being "managed", other than the payer categories listed above (Medicare, Medicaid, Self-Pay, CHAMPUS). Managed is defined as an organized program to control the use of health services, designed to ensure the medical necessity of the proposed service and the delivery of the service at the most effective level of care.

##### **Commercial**

(a.k.a. "traditional" commercial): This category includes all indemnity insurance payment arrangements including non-managed care discount off charge arrangements.

##### **Other**

Report everything not reported in the above categories.

#### **DISCHARGES**

An inpatient discharge is the termination of the granting of lodging in the hospital and the formal release of the patient (include patients admitted and discharged the same day). When a mother and her newborn baby are discharged at the same time, count one discharge. When the baby stays beyond the mother's discharge (boarder baby), count one discharge for the mother and another when the boarder baby is discharged. If a patient is discharged from an acute care unit and transferred to a Swing-Bed, there would be a count for acute discharge and another discharge from Swing-Bed when that occurs.

#### **GROSS INPATIENT CHARGES**

Gross inpatient charges are the sum of all charges made to inpatients for routine and ancillary services for the month, by payer category, including patients treated under capitated contracts. It should be recorded on an accrual basis at the hospital's established

rates including charges made to charity care patients. Do not reduce for discounts and/or allowances.

### **GROSS OUTPATIENT CHARGES**

Gross outpatient charges are the sum of all charges made to outpatients for hospital ancillary and clinic facility. It should be recorded on an accrual basis at the hospital's established rates including charges made to charity care patients. Do not reduce for discounts and/or allowances.

### **CONTRACTUAL ADJUSTMENTS**

Report the current month's difference between the amounts charged based on the hospital's full established (gross) charges and the amount received and/or due from the payer. For capitation contracts, appropriate adjustments should be recorded so only the amount of contract revenue is reflected after deducting the adjustments from charges.

### **CHARITY CARE**

The dollar amount of free care, based on a hospital's full established rates, provided to patients who are determined by the hospital to be unable to pay either all, or a portion of their bill. Charity refers to self-pay accounts that the patient is unable to pay and should be recorded in accordance with the hospital's policy for identifying charity care. Report this amount on a gross charge basis. Charity care write offs should be reduced by donations for charity care such as gifts, grants or endowments restricted by donors to assist charity patients, as well as payments received from state agencies for medically indigent programs.

### **PAYROLL EXPENSE - FACILITY PAYROLL**

Include all salaries and wages paid and accrued internally to **employees** including salaries or imputed salaries for members of religious orders. **ALSO REPORT** amounts paid for **contracted** and other **contracted labor** for services, which would otherwise have to be hired for internally. Salaries include vacation, holiday, sick leave, call pay and overtime pay.

### **EMPLOYEE BENEFIT EXPENSE**

Report the healthcare enterprise's share of social security (FICA), state and federal unemployment insurance, group health insurance, group life insurance, pensions, annuities, retirement benefits, worker's compensation, group disability insurance, and other employee benefit programs for all hospital employees.

### **SUPPLY EXPENSE**

Report those expenses that constitute supplies. This includes:

1. General supplies such as office;
2. Medical and ancillary department supplies; and
3. Support department supplies, i.e., housekeeping, dietary and maintenance.
4. Minor equipment not capitalized

**DEPRECIATION EXPENSE**

Include the depreciation and/or amortization recorded on land and buildings, fixed and moveable equipment, as well as leases and rentals. Do not include price level depreciation amounts, but rather depreciation recorded on an historical cost basis only.

**INTEREST EXPENSE**

Report interest expense on mortgages, bonds, notes, and any other short-term and long-term borrowings. Do not reduce for interest income on borrowed funds held by a trustee.

**BAD DEBT EXPENSE**

The current month's difference between the amount charged to patients and the amount received or expected to be received. Bad debts refer to self-pay or patient responsibility accounts which the patient is unwilling to pay.

**ALL OTHER EXPENSE**

Report all other incurred costs not reported in the other categories.

**OTHER OPERATING REVENUE**

This data element is analogous to "other revenue" defined in the Audit Guide (however, for **DATABANK** reporting purposes, tax subsidies should be separately disclosed. Other operating revenue normally includes revenue from services other than health care provided to patients, as well as sales and services to non-patients. Such revenue arises from normal day-to day operations of most health care entities and is accounted for separately from health care service revenue.