

DRAFT

DCH ICTF Data Subcommittee Data Definitions for SFY 2006

October 25 2005

Overall Principles:

1. Whenever possible, use the most recent data.
2. Data accuracy is even more important than timeliness.
3. Minimize the use of self-reported data.

Overall Comments:

1. Although the Department of Community Health (DCH) does not want to establish a process requiring systematic audits of hospital data, providers should recognize that any data submitted is subject to audit by the department.
2. Hospitals should retain copies and/or documentation for all data submitted should an audit be requested.
3. If DCH detects major data integrity issues, it should seek reasonable alternative sources.
4. A process should be developed to collect community benefits costs not captured in the indigent and charity care definitions to further demonstrate contributions hospitals make to their communities.

<u>Preferred Data Source</u>	<u>Time Frame</u>	<u>Accuracy Issues</u>	<u>Audit/Attestation Issues</u>	<u>Comments</u>
<p>Medicaid Data</p> <p>ACS data – HS&R for Medicaid Inpatient Days and Medicaid Payments</p>	<p>Hospital FY 2004</p>	<p>Include payment cycle 9 months after period. Also discussed using as long a run-out period as possible given the needs of DCH, but never less than six months.</p> <p>Despite assurances from DCH that the data from ACS is accurate, hospitals continue to express lingering doubts about the ability of ACS to produce accurate data about utilization and payments.</p> <p>Need to use the same time period for both inpatient days and payments.</p> <p>All payments should be reported on an accrual basis.</p>		<p>Survey due-dates may have to be adjusted to accommodate timelines</p> <p>If major problems with data are detected, DCH should seek reasonable alternative sources</p>

<u>Preferred Data Source</u>	<u>Time Frame</u>	<u>Accuracy Issues</u>	<u>Audit/Attestation Issues</u>	<u>Comments</u>
Medicaid Pending— Provider Survey	Hospital FY 2004	Self-reported data. A snapshot will be taken as of the report cut-off date. All Medicaid-pending patients will be considered uninsured for reporting purposes.		
Total Number of Hospital Inpatient Days—Medicaid Cost Report	Hospital FY 2004			
Out of State Medicaid Data—preference for HS&R from the other state(s), but if not available, then use self-reported data from a provider survey or an out of state log based on EOBs.	Hospital FY 2004	This will be self-reported data.		
Medicaid CMO data—deferred discussion until later	Hospital FY 2004			Hospitals feel strongly that DCH contracts with CMOs should include the requirement that CMOs report this data directly to hospitals.

<u>Preferred Data Source</u>	<u>Time Frame</u>	<u>Accuracy Issues</u>	<u>Audit/Attestation Issues</u>	<u>Comments</u>
<u>Peachcare Data</u> ACS data—HS&R for PeachCare Inpatient Days and PeachCare Payments	Hospital FY 2004			PeachCare data is not included in the calculation of the hospital-specific DSH limit (per CMS requirements), but in the past, DCH has considered PeachCare data in both the eligibility criteria to participate in ICTF and in the allocation of funds methodology.
<u>Uninsured Data – Defined as Individuals without Coverage for That Episode of Care</u>				Included in consideration for the cap if there is no third party coverage LIUR – Charity Care may be included
Medicaid Pending	Hospital FY 2004 – Considered uninsured as of survey cut-off date			
Unpaid co-pays and deductibles				Disallowed for purpose of determining hospital-specific DSH cap, but should this be collected for other purposes?

<u>Preferred Data Source</u>	<u>Time Frame</u>	<u>Accuracy Issues</u>	<u>Audit/Attestation Issues</u>	<u>Comments</u>
Patients who exceed lifetime cap	Hospital FY 2004			If had coverage but has capped out, that patient would be considered uninsured for that episode
<u>Other</u>				
Charity Care – Income > 125% and < 200% FPL			May be inconsistencies in how different hospitals classify charity and indigent care. Must recognize CON requirements in reporting.	
Cost-to-Charge Ratios – The Data Subcommittee unanimously supports using the overall facility Cost-to-Charge Ratio defined as: C Part 1 Line 101 Column 5 divided by C Part 1 Line 101 Column 8 – This <u>includes</u> observation beds. The subcommittee does not believe that this methodology will systematically have an impact on any particular group of hospitals.	Hospital FY 2004			