REPORT BY THE

AUDITOR GENERAL

OF CALIFORNIA

THE CALIFORNIA HEALTH FACILITIES COMMISSION CAN IMPROVE THE REPORTING OF HEALTH-CARE DATA

P-087

MAY 1982

California Legislature

Joint Legislative Audit Committee

925 L STREET, SUITE 750
SACRAMENTO, CALIFORNIA 95814
(916) 445-0371

WALTER M. INGALLS
CHAIRMAN

SENATE MEMBERS
ALFRED E. ALQUIST
RUBEN S. AYALA
ROBERT G. BEVERLY
PAUL CARPENTER
JOHN DOOLITTLE
KEN MADDY
VICE CHAIRMAN
ROBERT PRESLEY
ASSEMBLY MEMBERS
LEROY F. GREENE
CHARLES IMBRECHT
ERNEST KONNYU
RICHARD ROBINSON
MARILYN RYAN
JOHN VASCONCELLOS

STAFF
WALTER J. QUINN
CHIEF CONSULTANT
ROBERT W. LUCAS
PRINCIPAL CONSULTANT
CHARLES T. SCHULTZ
SENIOR CONSULTANT
GWEN YOUNKER
COMMITTEE SECRETARY

May 18, 1982 087

The Honorable President pro Tempore of the Senate
The Honorable Speaker of the Assembly
The Honorable Members of the Senate and the
Assembly of the Legislature of California

Members of the Legislature:

Transmitted herewith is the Auditor General's report on the California Health Facilities Commission. The Commission's 1981-82 estimated $2.8 million funding comes primarily from fees paid by hospitals and long-term care facilities. These funds are used to produce reports containing statistical and financial operating data on the 600 acute care hospitals and 1,200 long-term care facilities in California.

The Commission has developed uniform accounting and reporting systems which are not being followed by all of the hospitals and facilities. This results in inaccurate reporting which could lead to erroneous conclusions when utilizing the information. The primary users of the Commission's reports are hospital and long-term care facility administrators and health planners.

The Auditor General's report found that delays in obtaining the data and in processing the reports resulted in data that is up to three and one-half years old at the time of publication. Many administrators and planners reported that the data is too old for use in policy and planning decisions. The Commission has granted extensions rather than impose penalties for late filing.

The Commission has failed to make basic management decisions which would have alleviated most of these problems and improved the accuracy and usefulness of these reports. Without reporting accurate and timely data, the Commission has failed to meet its primary statutory responsibility.

It is unfortunate that consumers, providers, state agencies and the Legislature do not have the full benefit of reliable and timely statistical and financial data that the Commission was established to produce. There is no doubt in my mind that the information is needed and that the Commission can and should do a better job in meeting its responsibilities.

Sincerely,

WALTER M. INGALLS
Chairman, Joint Legislative
Audit Committee

WMI:smh

TABLE OF CONTENTS

SUMMARY

We have reviewed the California Health Facilities Commission's effectiveness in collecting, processing, and publishing health-care cost and statistical information. The California Health Facilities Commission (CHFC) is responsible for establishing and maintaining a system of uniform accounting and reporting for approximately 600 acute care hospitals and approximately 1,200 long-term care facilities in California. In addition, the CHFC is responsible for collecting financial data and other statistics from these health facilities and making this information available to the public. Generally, CHFC reports provide health facility administrators, public and private health planners, and consumers with financial and statistical information about health-care services in California.

To date, the CHFC has developed a standard accounting and reporting system for both hospitals and long-term care facilities. It has also generally published on time those reports that have specific deadlines. These reports provide information that was not previously available to health planners and consumers. However, our review indicated that the CHFC does not ensure that it collects and publishes accurate information because health facilities do not always report

health-care data accurately or in accordance with CHFC reporting requirements. Some health facilities have not implemented the CHFC's chart of accounts that provides standard reporting formats. Additionally, some health facilities do not correctly interpret the accounting and reporting requirements and therefore report inaccurate information to the CHFC. This has resulted because the CHFC quality control program does not include a review of health facilities to ensure that they have implemented the standard chart of accounts and reported the data in a manner that is consistent with reporting requirements. Also, the CHFC does not provide adequate instruction or guidance to health facilities because it does not routinely amend or clarify reporting requirements. Further, CHFC staff may provide inconsistent answers to health facility administrators who ask questions about reporting requirements. Finally, the CHFC has been unable to offer training programs to assist the staffs of health facilities in maintaining the CHFC accounting system and in preparing the disclosure reports. Consequently, health facilities do not always report uniform and accurate data to the CHFC. Inaccurate CHFC health-care information limits the ways in which health planners and the public can use the CHFC reports.

In addition to taking steps to ensure the reliability of health-care data, the CHFC needs to publish up-to-date health-care information in order to ensure that it is most

useful. Because the CHFC does not promptly collect annual disclosure reports from most hospitals and almost half of the long-term care facilities, data for health facilities in some CHFC reports are between one and one-half and three and one-half years old at the time of publication. One reason for the data's not being up-to-date is that the CHFC routinely grants extensions to health facilities' filing deadlines instead of assessing civil penalties for late filing; this practice does not encourage facilities to file their reports promptly. Also, the CHFC does not always promptly receive certain disclosure reports that are filed with the Department of Health Services. Furthermore, data in certain CHFC publications are not current because the CHFC data collection procedures are designed to control the data collection workload rather than to facilitate the timely publication of information. Finally, the CHFC's internal processing delays have also contributed to the delay in publishing reports.

During our review, we observed opportunities for the CHFC to improve its procedures to identify projects that would be most useful to the primary users of CHFC health-care data. Specifically, the CHFC needs to evaluate the effectiveness of its publications. In response to the recommendations we made during our review, the CHFC is taking steps to improve its system of assessing and meeting the needs of those who use CHFC health-care information.

In order to improve the accuracy of its data, the CHFC should review and improve its quality control system and ensure that it provides sufficient guidance to health facilities for preparing the disclosure reports. To ensure that the CHFC's information is up-to-date and of most use to health planners and consumers, the CHFC should institute procedures that will ensure the prompt collection of disclosure reports from health facilities. The CHFC should also review its publication periods and consider the benefits of publishing some of its reports on a semi-annual basis.

Finally, in response to Supplemental Language to the 1981-82 Budget Act, we have provided information on the activities of the Economic Criteria for Health Planning Committee of the CHFC.

INTRODUCTION

In response to Supplemental Language to the 1981-82 Budget Act and a request by the Joint Legislative Audit Committee, we reviewed the California Health Facilities Commission's effectiveness in collecting, processing, and publishing health-care cost information. We conducted our review under the authority vested in the Auditor General by Sections 10527 through 10528 of the Government Code.

BACKGROUND

The California Health Facilities Commission (CHFC) is an independent state commission authorized by the California Health Facilities Disclosure Act.* The CHFC is responsible for establishing a uniform accounting and reporting system for approximately 600 acute care hospitals and approximately 1,200 long-term care facilities in California. The CHFC is also responsible for collecting financial statistics and information on patients of these health facilities and making this information available to the public. To date, the CHFC has

* This act was originally known as the California Hospital Disclosure Act, Chapter 1242, Statutes of 1971, and was amended in 1974 to become the California Health Facilities Disclosure Act.

collected five years of data for hospitals and three years of data for long-term care facilities, and it has published numerous reports.

The CHFC consists of 15 members: eight persons from the general public and seven persons representing the interests of the health-care industry. Some of these members also serve on two standing committees of the commission, the Appeals Committee and the Management Committee. The Appeals Committee's responsibilities include hearing petitions from health facilities that request reviews of penalty actions taken by the CHFC or the executive director. The Management Committee advises the executive director on the administration of CHFC activities and develops operating policies that are approved by the CHFC. The CHFC also has the authority to appoint advisory committees, and to date it has formed the Economic Criteria for Health Planning Committee, the Patient Discharge Committee, and the Public Liaison Committee. The Economic Criteria for Health Planning Committee advises the CHFC on the annual report to the Legislature concerning health facility costs. The Patient Discharge Committee advises the CHFC on developing information about such patient characteristics as the dates of admission and discharge, the principal diagnosis, and the source of payment for services. The Public Liaison Committee advises the CHFC on reports that

would be useful to administrators, planners, and consumers who are interested in controlling the costs of providing health services.

The Health and Safety Code also established the Advisory Council to the CHFC to assist the CHFC in its operations. The Council is composed of 11 members representing the interests of the health care, labor, and financial communities.

The CHFC has approximately 70 staff members who are assigned to six branches: Accounting and Reporting Systems, Administration, Consumer Liaison, Data Systems, Public Disclosure, and Research. Staff members process the health-care data submitted by health facilities and develop reports to disseminate this information to the public. The CHFC publishes at least 40 different reports, all of which are authorized by the Health Facilities Disclosure Act. The act specifically requires three of those reports: the CHFC annual report to the Governor and State Legislature, the quarterly financial and utilization reports for hospitals, and the Economic Criteria for Health Planning Committee report on standards for health facilities. The other reports that the CHFC publishes provide detailed financial and statistical information on hospitals and long-term care facilities as well

as the results of CHFC research on health-care data. (Appendix A includes a list and descriptions of CHFC reports available to the public.)

Generally, CHFC reports provide health facility administrators, public and private health planners, and consumers with statistical information about health-care services in California. Specific information in the reports, such as number of patients, facility costs, staffing patterns, and revenue sources, assists these users in developing long-range plans, comparing rates and fees, and making health-care policy decisions.

The CHFC's funding comes primarily from fees paid by hospitals and long-term care facilities. These fees are based upon a percentage of the gross operating costs of each facility. Other revenue is derived from the sale of CHFC documents, from penalties for late reports, and from surplus money investments. According to the 1982-83 Governor's Budget, the CHFC estimates its fiscal year 1981-82 expenditures to be approximately $2.8 million.

SCOPE AND METHODOLOGY

The objectives of the audit included reviewing the effectiveness and efficiency of the CHFC during the past three years. In evaluating the effectiveness of the CHFC, we first attempted to determine if the CHFC had complied with basic mandates for establishing uniform reporting requirements and publishing various reports. To evaluate the CHFC's effectiveness further, we reviewed its systems for collecting and processing data, determined whether facilities comply with reporting requirements, and examined how the data are used by health planners and consumers. Specifically, we evaluated CHFC procedures for maintaining a standard accounting system for health facilities and for collecting, processing, and publishing health-care cost data. Our audit included an analysis of the CHFC's procedures for ensuring that health facilities report data in accordance with the provisions of the CHFC standard accounting and reporting manual. We also assessed the CHFC's procedures for the timely collecting, processing, and publishing of information on the cost of health care. Finally, we evaluated the CHFC's procedures for identifying the needs of health planners for health-care information.

To conduct our review, we interviewed individuals at the CHFC and at both public and private health agencies. We also reviewed CHFC records and files. In order to evaluate the usefulness and accuracy of CHFC reports and to test the need for training programs, we sent a detailed questionnaire to over 680 administrators of hospitals and long-term care facilities and to representatives of other groups and agencies interested in CHFC health-care information. We randomly selected questionnaire recipients from the CHFC health facility and CHFC bulletin mailing lists. We received over 240 completed questionnaires. We provide detail about questionnaire responses in the text of this report; however, we do not make projections about these responses to the total population of the CHFC report users. (Appendix B provides more information regarding the questionnaire responses.)

At seven hospitals and seven long-term care facilities throughout California, we tested the records used to prepare the 1979-80 disclosure report. The disclosure report is a document that itemizes financial and statistical information on the annual operation of a health facility; health facilities must submit these documents to the CHFC at the end of each fiscal year. We selected fiscal year 1979-80 because it is the most recent period for which the CHFC has published summary data for both types of facilities. Our analysis included a review of the accounting and statistical

records that health facilities use to maintain and report health-care information to the CHFC. At the hospitals, we analyzed, when possible, the expenditures and statistics reported in the annual disclosure report for certain departments and services. We also analyzed certain expenditures and statistics presented in the 1981 third quarter financial report, the most recently published quarterly report. At long-term care facilities, we examined the method used to develop and report expenditures for six expense items included on CHFC reports: administration, dietary services, laundry and linen, nursing services, housekeeping, and plant operations and maintenance. Although we reviewed the procedures that health facilities used to prepare the 1979-80 disclosure report, we also examined the systems used to ensure that the current methodology is not significantly different from that used in 1979-80.

Finally, we were asked to review the activities of two CHFC committees: the Public Liaison Committee and the Economic Criteria for Health Planning Committee. Based on the responsibilities assigned to each committee and our discussions with legislative staff, we limited our review to the most recent activities of the Economic Criteria for Health Planning Committee.

Although our report identifies weaknesses in the CHFC's current system to collect, process, and publish health-care data, we could not measure the overall reliability of the CHFC's data base because we did not conduct a complete review of the disclosure reports submitted by health facilities throughout the State. We did not attempt to assess the costs associated with ensuring that all health facilities report data accurately. Also, our report analyzes certain issues and presents recommendations that could affect CHFC budget requirements. However, we have not reviewed the appropriateness of the CHFC's overall budget because the Legislative Analyst has provided such an analysis and has included recommendations in the 1982-83 Analysis of the Budget Bill.

AUDIT RESULTS

THE CALIFORNIA HEALTH FACILITIES COMMISSION CAN IMPROVE THE REPORTING OF HEALTH-CARE DATA

To help promote economy and efficiency in the provision of health-care services, the California Health Facilities Disclosure Act requires all health facilities in the State to file public disclosure reports to the California Health Facilities Commission (CHFC). The code states that these disclosure reports are intended to enable public agencies and other entities that purchase publicly financed health-care plans or programs to make informed decisions and to establish fair and reasonable reimbursement rates for health-care services. To collect uniform data, the CHFC developed a standard accounting and reporting system that hospitals and long-term care facilities are required to use for reporting financial and statistical information to the CHFC. After the CHFC collects and processes this information, it disseminates the information to the public by publishing reports.

To date, the CHFC has developed a standard accounting and reporting system for both hospitals and long-term care facilities. It has also generally published on time those reports that have specific deadlines. These reports provide

information that was not previously available to health planners and consumers. However, the CHFC does not ensure that it collects and publishes reliable information because health facilities do not always report health-care data accurately or in accordance with the reporting requirements established by the CHFC. Furthermore, the annual data for most of the facilities in some CHFC reports are between one and one-half and three and one-half years old because the CHFC does not collect and process disclosure reports promptly. Finally, the CHFC's current planning system may not ensure that certain reports published by the CHFC provide information that is most useful to health planners and consumers.

Because it does not ensure that certain data it collects and publishes are reliable and current, the CHFC may provide health planners and consumers with information that may be of limited use for planning or promoting efficiency and economy in the provision of health-care services. Unreliable data may affect the nature of decision making; users may either choose not to use the data or they may make decisions based upon data that are not totally accurate.

Need for Improved Reliability of Health-Care Data

The CHFC needs to improve its procedures for collecting health-care information in order to ensure that its publications are reliable. Although the CHFC has established a system for collecting standardized information from health facilities, not all of the data that it collects are reported in accordance with reporting requirements. Because some health facilities have not correctly implemented or interpreted the CHFC standard accounting and reporting requirements, some information in the CHFC hospital and long-term care facility publications is not uniformly reported; it may thus be difficult to compare the data. The CHFC's quality control process is not adequate to ensure that facilities correctly implement and interpret reporting requirements. Furthermore, the CHFC does not provide adequate instruction or guidance to health facilities on accounting and reporting requirements. Unreliable health facility data may limit the use of CHFC reports.

Lack of Uniform Reporting by Some Health Facilities

Some health facilities have not implemented the CHFC's uniform reporting requirements that establish standard reporting formats. Additionally, some facilities do not

correctly interpret the accounting and reporting requirements. Consequently, health facilities report information to the CHFC that is not reliable or uniform.

To meet the mandates of the California Health Facilities Disclosure Act, the CHFC contracted with a private accounting firm to develop the accounting and reporting manual for California hospitals. This manual establishes a system of uniform accounting records and provides uniform procedures for hospitals to report financial and other management data to the CHFC. Before the CHFC adopted it in 1973, the manual was extensively reviewed by the CHFC Advisory Council and by staff members of individual hospitals and hospital organizations. Using similar procedures in 1976, the CHFC adopted an accounting and reporting manual that established uniform procedures for California long-term care facilities.

The accounting systems for both hospitals and long-term care facilities are based upon a standardized chart of accounts. A chart of accounts is a systematic listing of all accounts applicable to the financial operation of an organization. The CHFC's chart of accounts for both hospitals and long-term care facilities includes accounts that are standard for most businesses as well as accounts that are unique to the operation of health facilities, such as accounts

for patient admissions and nursing services. The CHFC account items are structured so that a facility can easily accumulate, classify, and summarize financial and other statistical information. All hospitals are required to implement the CHFC chart of accounts; however, long-term care facilities may be exempted from implementing the exact numbering system used in the CHFC chart of accounts only if the facility has an adequate cross-indexing system that converts the facility's own chart of accounts to that of the CHFC.

We examined the methods used by seven long-term care facilities and seven hospitals to prepare their disclosure reports and submit data to the CHFC. Five of the seven long-term care facilities we reviewed had not implemented the CHFC Chart of Accounts or cross-indexed their own chart of accounts to that of the CHFC. Two of the seven hospitals we reviewed had not implemented the CHFC chart of accounts. One of the long-term care facilities has since implemented the CHFC chart of accounts. Some of these facilities had implemented accounting systems that were similar to the CHFC's but that were not always consistent with the CHFC's accounting requirements. When facilities do not implement the CHFC standard chart of accounts and thus report data that are inconsistent with CHFC provisions, these data misrepresent a

facility's financial or management operations and limit the ability of health planners and consumers to compare and analyze costs accurately.

For example, one long-term care facility operates both a nursing home and a residential center for senior citizens. In order to receive federal support for the residential center, the facility states that it is required to use the chart of accounts and the accounting system prescribed by the Federal Department of Housing and Urban Development. This facility did not, however, use the CHFC chart of accounts or cross-index its system to the CHFC chart of accounts as required by the Health and Safety Code and by CHFC regulations. As a result, some of the facility's cost information was incorrectly reported to the CHFC. The CHFC chart of accounts for long-term care facilities specifies that only expenses that are directly related to nursing care for patients should be reported as nursing services. This facility, however, reported expenses of over $48,000 in nursing services that should have been reported as expenses for housekeeping, laundry and linen, administration, and social services. This amount inflated the facility's actual expenses and average cost per patient day for nursing services by over 10 percent and at the same time reduced the average cost of services provided by the other departments.

Another facility that has not implemented the CHFC chart of accounts recorded expenses for nursing services improperly. Because the facility did not use the CHFC chart of accounts, it inappropriately recorded approximately $36,000 in expenses for plant maintenance, pharmaceutical services, and reimbursable or ancillary services as a nursing services expense item. Although we could not determine the fiscal impact of incorrectly classifying the expenses for each of the departments, the average cost per patient day for nursing services was inflated by approximately 8 percent.

We observed a similar situation in a hospital that did not implement the chart of accounts. This facility did not implement the CHFC's provisions for reporting equipment depreciation and failed to include depreciation expenses for two departments. As a result, the expenses for these two departments were understated, lowering the average cost per patient day for the departments' services.

In addition to not implementing the CHFC chart of accounts, personnel at long-term care facilities and hospitals we visited did not always correctly interpret some of the CHFC's reporting requirements. As a result, some long-term care facilities included expenses in inappropriate categories. For example, the CHFC chart of accounts for long-term care facilities requires that expenses for keeping the interior of

the facility clean (housekeeping) be reported separately from those expenses incurred for maintenance and repair of the facility (plant maintenance and operations). However, one long-term care facility's expenses for housekeeping were much lower than those expenses for another facility of similar size and location. According to the facility, the salaries of the housekeeping staff are reported with plant maintenance and operations expenses because these staff members do both housekeeping and plant maintenance chores. As a result, the expenses for housekeeping as reported to the CHFC were lower than the actual expenses incurred, and the average cost per patient day for housekeeping was understated. In a similar case, another long-term care facility erroneously reported expenses for nursing services because it included expenses for non-nursing-related supplies, workers' compensation, and ancillary services (that is, expenses for services for which patients reimburse the facility). The misclassified expenses for supplies could not be easily identified; however, the expenses for workers' compensation and ancillary services alone inflated the facility's actual expenses for nursing services by approximately $16,000, or 7 percent of the total.

Like some long-term care facilities, certain hospitals do not always correctly follow the CHFC accounting and reporting provisions to allocate expenses properly or to prepare statistical information. As a result, there have been

instances in which items reported to the CHFC were either understated or overstated. For example, at least two hospitals overstated expenses for administrative services by not charging employee benefits to the appropriate hospital departments. The CHFC chart of accounts specifies that payroll-related employee benefits should be included as direct expenses in the hospital department where the employees earn those benefits. Both hospitals reported these benefits as an administrative expense, resulting in the hospitals' overstating their actual expenses and their average costs per patient day for these services. By misclassifying these expenses, one hospital overstated its actual expenses for administrative services by over $1.6 million, inflating the facility's expenses for this service by almost 49 percent. The amount reported by the second hospital was overstated by approximately $333,000, or 23 percent of the hospital's total cost of administrative services. As a result of these overstatements, the average cost per patient day was higher than the actual cost per patient day for administrative services at these facilities.

Inaccurate reporting by health facilities obviously has a direct effect on the reliability of the information published by the CHFC. The CHFC publishes various reports that provide details on the expenditures of health facilities and the costs of providing services to each patient. When a facility makes a reporting error that results in an

understatement or an overstatement of expenses, that error may misrepresent the facility's actual costs and thus make for unreliable cost comparisons and analyses.

The CHFC Quality Control Process Is Not Adequate to Detect Inaccurate Reporting

The CHFC cannot ensure that the data it collects and processes are accurate because it does not have an adequate quality control process to ensure that facilities are correctly implementing the CHFC uniform reporting requirements and submitting reliable data to the CHFC. Specifically, the CHFC does not evaluate the health facilities' accounting and reporting systems to determine if facilities have implemented the CHFC chart of accounts.

The quality control system that the CHFC employs to test the accuracy of data includes a review of disclosure reports for completeness and reasonableness. This process subjects the data to over 100 manual and computer edit reviews. When the CHFC receives a facility's report, the data are entered into the CHFC's data processing system for a series of computerized edit checks. The computer's review ensures that statistics are entered where appropriate and verifies that numbers are transferred correctly between columns and pages. After reviewing all the errors detected by the computer as well

as those errors identified during a manual review, the CHFC staff make the necessary revisions to the report. If additional information from the facility is needed, the analysts may call the facility or return the report to the facility for correction. This process appears adequate to ensure that the data, as reported, are complete; however, this process does not ensure that facilities adhere to the CHFC reporting requirements and accurately report data to the CHFC.

According to the CHFC staff, the CHFC's quality control system includes three additional procedures to ensure that facilities report data accurately. First, each facility certifies under penalty of perjury that its disclosure report has been prepared in accordance with the CHFC manual. Second, the CHFC occasionally revises or clarifies those reporting manual requirements that would result in inaccurate reporting. Third, during the edit review, the computer verifies the reasonableness of particular entries on the disclosure report. For example, one analysis will ensure that a facility's occupancy rate is between 25 percent and 100 percent, while another test reviews the costs per unit of service to verify that the amount reported is not excessively more or less than average for all facilities in the previous year. However, none of these quality control procedures determines whether a facility has in fact implemented the standard chart of accounts.

Before 1981, the CHFC could determine, to a limited extent, if long-term care facilities used the CHFC chart of accounts to report data by reviewing the results of audits conducted by the Audits Branch of the Department of Health Services (DHS). When the DHS auditors conduct field reviews of long-term care facilities that receive Medi-Cal funding, they also determine whether the facility has adopted the CHFC's chart of accounts or has a cross-indexed chart of accounts. The DHS then reports its findings to the CHFC in DHS audit reports. Although the DHS auditors do not completely review a facility's implementation of the chart of accounts, the audit reports do provide limited information on facilities' compliance with certain reporting requirements. CHFC staff have indicated that, at one time, they monitored the findings of the Audits Branch, but they no longer do so. However, as a result of our review, CHFC staff have taken steps to resume this monitoring. Although the DHS also conducts field reviews of hospitals that receive Medi-Cal funding, the DHS does not currently review the hospitals' implementation of the CHFC chart of accounts.

The CHFC has recognized the need to conduct field reviews of hospitals and long-term care facilities to determine the reliability of reported information. In a 1981-82 Budget Change Proposal, the CHFC has requested one additional staff

position to enable it to test hospital reports. The Department of Finance denied this request, however, because it believed the CHFC already had sufficient staff and because of statewide fiscal constraints. In addition to requesting more staff, the CHFC has also attempted to coordinate field reviews with the Department of Health Services' Audits Branch; negotiations have not been completely successful, however.

Although the CHFC states that it does not have the staff available to audit health facilities, the CHFC potentially could use some monitoring techniques without increasing its staff. Initially, the CHFC could continue its discussions with the Department of Health Services' Audits Branch and negotiate an interagency agreement by which DHS auditors will review the chart of accounts and the accuracy of the reported information when they conduct field reviews of hospitals and long-term care facilities that receive Medi-Cal funding. Also, the CHFC could implement a self-audit procedure by which health facilities evaluate their operations in a review document that is designed to identify whether the chart of accounts has been adequately implemented. Facilities would return this document to the CHFC along with their disclosure reports so that CHFC staff can identify potential reporting problems that need correction. Finally, using its current staff, the CHFC could conduct limited tests at health

facilities to observe the methods used to prepare disclosure reports. This testing procedure could be part of an ongoing training program for the CHFC analysts who examine the disclosure reports for technical errors. Although implementing quality control procedures such as the above cannot guarantee that all health facilities will adhere to CHFC reporting requirements, quality control efforts may increase the accuracy of the data provided to the CHFC and allow the CHFC to measure the overall reliability of its health-care information.

The CHFC Does Not Provide Adequate Guidance to Health Facilities

The CHFC has not provided health facilities with adequate guidance so that they can meet accounting and reporting requirements and thus prepare the CHFC disclosure reports fairly, accurately, and efficiently. According to CHFC staff, the CHFC has included instruction packages along with the reporting forms for nine of the twelve health facility reporting periods. These instruction packages highlight certain reporting requirements and provide special instructions for completing the forms. In addition, the CHFC staff routinely answer questions from health facility administrators regarding the disclosure report. However, the CHFC does not have a formal system to routinely review and amend or clarify reporting requirements. Also, because there is no system to

ensure such consistency, CHFC staff may not always provide consistent answers to administrators asking questions about reporting requirements. Finally, the CHFC has been unable to routinely offer training programs to health facilities' staff because of budget constraints; facility administrators believe that such training programs would assist them in maintaining the CHFC accounting system and in preparing the disclosure report.

The CHFC has only sporadically revised the CHFC accounting and reporting manuals for both hospitals and long-term care facilities; most of the revisions have been made to the manuals for hospitals. CHFC staff members reviewed and revised specific provisions in the hospitals' accounting and reporting manual 15 times between 1974 and 1981. The CHFC staff made these revisions in response to changes in legislative mandates, to recommendations by CHFC or health facilities staff, and to recommendations from a special task force composed of representatives from state government, hospitals, long-term care facilities, and the accounting profession. Unlike the manual for hospitals, the accounting and reporting manual for long-term care facilities was revised only 3 times between 1977 and 1980. These revisions added or clarified accounting and reporting procedures and incorporated the legislative mandate to integrate the CHFC and the Medi-Cal disclosure reports.

The CHFC also attempts to clarify certain provisions of the accounting and reporting manual by issuing interpretation letters when the CHFC determines that such clarifications will benefit most facilities. Interpretation letters differ from revisions in that revisions change the reporting requirements while interpretation letters provide clarification of the requirements. Between 1974 and 1981, the CHFC sent 52 interpretation letters to hospitals; the CHFC has not, however, issued an interpretation letter to hospitals since early in 1981. In 1977, the CHFC sent 4 interpretation letters to long-term care facilities, but it has not issued any letters to long-term care facilities since then.

According to a CHFC official, the CHFC revises the health facility accounting and reporting manuals or issues interpretation letters only when the CHFC's accounting and reporting staff identify such a need or in response to changes in legislative mandates. However, staff members do not meet regularly to discuss possible revisions of the accounting and reporting procedures. For both types of health facilities, we identified inconsistencies in reporting that demonstrate the need for the CHFC to review the manuals and to issue additional revisions or interpretation letters. For example, the CHFC instructions to hospitals for preparing the medical staff profile report do not specify how to classify a physician who practices medicine in more than one specialty. Furthermore,

the instructions do not indicate how to classify a physician who is certified in one specialty but practices in another specialty. As a result, at least three hospitals may have reported these statistics inconsistently.

The CHFC manual also does not state whether employee physicals, workers' compensation cases, or subsequent visits by previous emergency outpatients are to be included as emergency room visits. We believe the insufficient instructions caused four hospitals to include some of these items as emergency room visits while one hospital did not. By not including the above items, this one hospital understated its emergency room visits by 1,761 visits, or approximately 40 percent of the total visits reported to the CHFC.

We observed similar problems at long-term care facilities. For example, the CHFC manual does not adequately describe how to classify expenses for the utilization review, which confirms that patients are receiving the appropriate level of care. While the utilization review is listed as a nursing service in one section of the manual, it is described as an administrative expense in another section of the manual. Two facilities reported the utilization review as an administrative expense while another four facilities listed it as a nursing service. In another example, one section of the manual specifies that expenses for advertising should be

classified as an administrative expense. However, a different section of the manual states that when this expense is related to employee recruitment, it should be allocated to the specific department that is doing the recruiting. Because of the inconsistent references in the manual, at least four facilities included all of their advertising expenditures as administrative items rather than assigning the costs to the appropriate service departments of the facility.

Insufficiently defined CHFC reporting requirements may have an effect on the accuracy of the CHFC reports that provide analyses of health facility data. For example, the CHFC is preparing to publish effectiveness standards for hospitals and long-term care facilities; these standards are based upon the data that facilities provided in their disclosure report. Under the law mandating these effectiveness standards, Health Systems Agencies (HSAs) are required to consider such standards in developing elements of the statewide health plan.* If a facility reports data to the CHFC that do not depict its true expenses, the facility may inappropriately meet or fail to meet a particular standard of effectiveness. For instance, one facility included a nonpatient-related expense when reporting its dietary expenses because the

* Health Systems Agencies identify community needs for health care services and prepare long-range health plans for designated areas of the State.

accounting and reporting manual did not specify where such expenses should be recorded. This facility reported approximately $20,000, or 25 percent of its total expenses for food, as an expense for meals for patients of the facility. In fact, these expenses were for providing meals to elderly people who were not patients of the facility but who rather lived in their own homes. Misclassifying these expenses inflated the facility's direct per patient day expense for dietary services from about $4.00 to over $5.25.

Although there are several means by which the CHFC could identify reporting requirements that may need revision or clarification, the CHFC does not currently use these means. For instance, the CHFC has not requested suggestions from health facilities for needed revisions or clarifications. Also, the CHFC staff do not maintain records of health facility administrators' questions about accounting and reporting requirements to track the reporting requirements that may need to be amended or clarified.

Furthermore, the CHFC does not currently review health facilities' reporting errors that the CHFC staff have identified on previous disclosure reports. To identify recurring reporting problems that unclear requirements could cause, the CHFC staff could look for patterns of reporting errors made by all health facilities. The CHFC already has the

computer capability to identify reporting errors detected in the CHFC technical review. The current CHFC data base stores information on reporting errors made by both hospitals and long-term care facilities.

In addition to not making routine reviews of reporting requirements, the CHFC may not be providing consistent verbal responses to inquiries from health facility administrators. Health facilities frequently contact the CHFC staff and request verbal interpretation of CHFC reporting requirements. During our review, we identified seven different staff members who interpret the accounting and reporting manual to answer questions from health facilities. However, the CHFC does not have a system to ensure that staff members correctly interpret the reporting requirements and provide consistent and accurate instructions to health facilities.

To determine whether the CHFC staff uniformly interpret the CHFC manual, we asked seven CHFC staff members and managers how certain health facility expenses and statistics should be reported to the CHFC. Their responses showed that CHFC staff inconsistently interpret some of the accounting and reporting requirements. This inconsistent interpretation could result in inconsistent instructions given to health facility administrators. For example, in considering the requirements for reporting hospital emergency room visits,

two CHFC staff members responsible for hospital disclosure reports defined emergency room visits as including emergency room patients, follow-up visits, employee physicals, and workers' compensation cases. However, two other CHFC staff members felt that only those visits during which medical attention is given to emergency patients should be reported in this category. In another example, two CHFC staff members responsible for long-term care facility disclosure reports felt that revenues and costs for a particular nonpatient-related food program should be reported in the dietary expense item, while a third staff member said that this program should be recorded as an ancillary service.

According to CHFC staff members, when they are unsure of correct reporting requirements, they converse with other CHFC staff members to obtain an interpretation. However, the CHFC program managers do not meet regularly with staff to discuss problems in interpreting the accounting and reporting manual. As a result, staff may provide inconsistent interpretations to health facilities.

In the past, the CHFC has offered training programs to clarify reporting requirements. However, because of a lack of staff resources, the CHFC has offered only a limited number of these training programs to health facility administrators and to individuals who prepare the CHFC disclosure reports.

Because the CHFC accounting and reporting manuals are complex and the reporting requirements are detailed, training programs could help increase the uniformity of the data reported to the CHFC, thus making that data more reliable.

CHFC records indicate that the CHFC has offered training programs either approximately every two years or when needed to clarify significant changes in the reporting requirements. Since 1974, the CHFC has held at least four training programs for hospitals and four programs for long-term care facilities. The CHFC's first training program for health facilities introduced the CHFC's role and function and presented the accounting and reporting requirements. The CHFC subsequently offered training on completing the CHFC disclosure report forms. The CHFC has also used training programs to present information about changes in reporting requirements.

To determine the interests in training programs for facility staff members or consultants who prepare disclosure reports and other individuals who use the CHFC reports, we sent questionnaires to health facility administrators and health planners. Of those responding to our question regarding interest in attending training programs, almost 60 percent indicated that they would attend CHFC training sessions dealing with CHFC accounting and reporting procedures if these sessions were offered. Such sessions could focus, for example, upon

accounting techniques as well as reporting errors that occur frequently. Table 1 below shows the number of hospital and long-term care facility administrators and the number of Health Systems Agencies and other public and private health planners who indicated that they would attend CHFC training sessions.

TABLE 1

INTEREST OF ADMINISTRATORS AND HEALTH PLANNERS IN ATTENDING CHFC TRAINING SESSIONS FOR PREPARING DISCLOSURE REPORTS

	Would Attend		Would Not Attend		Total Responding To Question	
	Number	Percent	Number	Percent	Number	Percent
Hospital administrators	33	63%	19	37%	52	100%
Long-term care facility administrators	40	56%	32	44%	72	100%
Health planners	25	60%	17	40%	42	100%
Total	98	59%	68	41%	166	100%

Unreliable Data May Limit Use of CHFC Reports

The reliability of the CHFC data base may affect the way in which administrators, health planners, and the public use the CHFC reports. Although we did not measure the overall accuracy of the CHFC data base, we sent a questionnaire to health facility administrators and health planners to gather information on the use of CHFC reports and on how inaccurate

reporting affected the use of these reports. Sixty-four percent of the respondents indicated that they use the CHFC reports. As the following table shows, the primary users of CHFC reports are hospital administrators and health planners.

TABLE 2

ADMINISTRATORS AND HEALTH PLANNERS
WHO USE CHFC REPORTS

	Use Reports		Do Not Use Reports		Total	
	Number	Percent	Number	Percent	Number	Percent
Hospital administrators	47	72%	18	28%	65	100%
Long-term care facility administrators	43	41%	61	59%	104	100%
Health planners	64	88%	9	12%	73	100%
Total	154	64%	88	36%	242	100%

Of the 154 respondents who reported that they do use CHFC reports, 145 respondents, or 94 percent of the users, indicated how they use these reports. Our survey shows that 136 of those 145 respondents (94 percent) stated that they use the reports for general information. However, only 22 percent of the hospital administrators, 26 percent of the long-term care facility administrators, and 15 percent of the health planners use particular reports for controlling health-care costs. Also, only 13 percent of the hospital administrators,

11 percent of the long-term care facility administrators, and 8 percent of the health planners use certain reports for setting rates for services. (Appendix C provides specific information on the primary users and the primary uses of the CHFC reports.)

We also asked administrators and health planners for examples of the ways in which they use the CHFC reports. Eighty-seven indicated that the reports could be used for budget planning or for comparing facilities' costs of providing certain services. Further, 24 respondents indicated that the data could be used for analyzing trends and for developing project proposals.

Our survey indicated that 36 percent of the respondents do not use the reports. Fifty-three respondents reported that they either do not use the CHFC reports or make only limited use of them because they believe that these reports are inaccurate or because the data do not represent actual conditions. (Appendix D discusses further why administrators and health planners do not use CHFC reports.) Twenty-four percent of the respondents reported that they use the CHFC reports even though they felt that the reports are inaccurate or not representative.

We also attempted to determine why respondents felt that CHFC reports are inaccurate. Sixty-nine percent of the respondents to our question said that the data were inaccurately reported to the CHFC, and 49 percent stated that the reporting and accounting techniques were inadequate. Furthermore, 20 percent of the respondents stated that published reports are inaccurate because the CHFC makes inappropriate changes to the disclosure reports. (Appendix E provides detailed information on why respondents believe the CHFC data are not accurate.)

The CHFC Needs to Publish More Current Health-Care Information

Certain CHFC reports present annual data that are from one and one-half to three and one-half years old when they are published. The CHFC's annual health-care information is not more current for at least three reasons: the CHFC's policy for collecting data does not require or encourage health facilities to adhere to reporting deadlines; the CHFC's publication periods are designed to control the data processing workload rather than to facilitate the timely publication of information; and there are delays in the processing of health facility reports. As a result, certain data published by the CHFC may be of limited use to some health planners and consumers who need current information to promote economy and efficiency in providing health services.

The CHFC has published the three reports specifically required by law generally within the mandated deadlines. The CHFC has submitted the annual report to the Legislature by November 1 of each year. The CHFC has also collected summary financial and utilization data from hospitals within 45 days of the end of each quarter, and it has usually published this data within 105 days of the end of each quarter. The CHFC has been late in publishing the Economic Criteria for Health Planning Report because of the time necessary to develop expenditure estimates and the standards of effectiveness. The CHFC combined the 1981-1982 and 1982-83 ECHP committee reports into one report that it will publish in June 1982.

Improvements Needed in the Prompt Collection of Data

The CHFC's policy for collecting data from health facilities does not encourage facilities to meet reporting deadlines. According to the Health and Safety Code, the CHFC is required to collect annual financial disclosure reports from health facilities within four months after the end of each facility's accounting year. However, approximately 69 percent of the hospitals and 46 percent of the long-term care facilities did not file their 1980-81 disclosure reports until after the four-month deadline.

To discourage facilities from filing late reports, the Health and Safety Code states that when a facility is late in filing its disclosure report, it is liable for a civil penalty of $100 per day. Under certain conditions, the Executive Director of the CHFC may grant an extension. Additionally, a CHFC regulation allows the Appeals Committee to waive or reduce penalties. Instead of penalizing institutions that submit late reports, however, the CHFC has routinely granted extensions giving facilities additional time to file their reports. The CHFC has also reduced, waived, or failed to collect 47 of the 50 penalties that it imposed in fiscal year 1980-81.

The Health and Safety Code authorizes the CHFC to grant an extension to the deadline for filing a facility disclosure report when a facility can show sufficient cause for the delay. A CHFC regulation allows for extensions of up to 90 days. Current CHFC practices, however, do not discourage facilities from filing late disclosure reports. Instead of assessing civil penalties for disclosure reports that are filed after CHFC deadlines, the Executive Director of the CHFC usually grants extensions to allow health facilities additional time to file their reports. In fiscal year 1979-80, the CHFC granted extensions to 56 percent of the hospitals and 35 percent of the long-term care facilities. For hospitals, the extensions averaged 40 days beyond the filing deadline; the

average extension for long-term care facilities was 28 days. In fiscal year 1980-81, the CHFC authorized extensions for 69 percent of the hospitals and 42 percent of the long-term care facilities, an increase over the previous year. Although the number of extensions increased in fiscal year 1980-81, the average length of the extensions decreased to 40 days beyond the filing deadline for hospitals and 10 days for long-term care facilities. Generally, both types of facilities requested extensions because of internal staff problems or because the lack of audited financial data prevented facilities from filing the disclosure reports promptly.

Even though health facilities may request extensions, some facilities have filed late reports without an approved extension or have filed reports after the extension deadline had passed and fines had been assessed. For fiscal year 1979-80, 13 percent of the hospitals and 9 percent of the long-term care facilities filed late reports; these reports were late by an average of 25 days and 18 days, respectively. In fiscal year 1980-81, the number of facilities filing late reports without CHFC authorization dropped significantly: less than 1 percent of the hospitals and 4 percent of the long-term care facilities filed late reports.

The Health and Safety Code states that facilities filing late reports are liable for a civil penalty of $100 for each day that the disclosure report is late. When a penalty is imposed on a facility, that facility may appeal the penalty to the CHFC Appeals Committee. According to Title 4 of the California Administrative Code, the Appeals Committee may waive or reduce a penalty when the facility can show "good and sufficient cause." Although the policy of the Appeals Committee has been to waive or reduce penalties from $25 to $100 per day depending on the number of days that the report is late, the CHFC has not established standards for determining good and sufficient cause. CHFC records indicate that all penalties were reduced when facilities could demonstrate that willfull neglect was not responsible for the late filing of the CHFC disclosure report. For both hospitals and long-term care facilities, the CHFC reduced or waived the penalty for all facilities that filed a petition. For the 5 hospitals that appealed the CHFC penalties in fiscal year 1980-81, the Appeals Committee reduced or waived a total of $16,200 in penalties to $200. For the same year, the Appeals Committee reduced or waived penalties against the 13 long-term care facilities appealing CHFC penalties from about $34,100 to approximately $10,000.

The Health and Safety Code does not specifically provide for the waiving or reducing of penalties even though the CHFC has promulgated California Administrative Code regulations that do so. The legal counsel for the CHFC has requested a formal opinion from the Attorney General to determine whether the Appeals Committee may continue its practice of waiving and reducing penalties. The Attorney General's opinion is not yet available.

In addition to not encouraging facilities to file timely reports, the CHFC does not always receive the annual long-term care facility reports that are initially filed with the Department of Health Services' Audits Branch until after the CHFC deadline. The Audits Branch receives both its own and the CHFC's copies of the disclosure reports from long-term care facilities and then forwards the disclosure reports to the CHFC. However, the Audits Branch has not always forwarded the CHFC's copies until after the CHFC deadlines. As a result, the CHFC has erroneously initiated penalty actions against at least three long-term care facilities.

CHFC Reporting Periods Do Not Facilitate Publication of Up-to-Date Information

Another reason that the data in the CHFC's annual publications are between one and one-half and three and one-half years old is that the CHFC's data collection procedures are designed to control the data processing workload rather than to facilitate the timely publication of information. Some health planners have indicated that information that is more than one year old has limited use.

CHFC reports present yearly data for health facilities. The Health and Safety Code requires health facilities to submit their annual disclosure reports within four months of the end of their accounting years. In order to control its workload, the CHFC established yearly data collection periods that begin the same day that a major portion of facilities end their accounting years. Thus, since over 40 percent of the hospitals have accounting years ending June 30, the CHFC data collection period for hospitals begins on June 30 and ends on the following June 29. Similarly, the accounting year for long-term care facilities usually ends on December 31, and the CHFC data collection period for these facilities begins on December 31 and ends on the following December 30. Such collection periods enable the CHFC to gather

the bulk of the health facility cost reports at the beginning of the data collection period and thereby control the data processing workload during the year.

However, not all hospitals have July-to-June accounting years, and not all long-term care facilities have January-to-December accounting years. Thus, although most health facilities submit their cost reports during the first half of the CHFC's collection period, facilities whose accounting years end at various other times submit their cost reports later in the collection period. Consequently, at the end of any given data collection period, the age of the data will range from a few days old to twelve months old. Furthermore, because health facilities have up to four months after the end of their accounting years to submit reports, by the time the last facility submits its report to the CHFC, at least 42 percent of CHFC's data for a given year may be 16 months old. Additionally, since it takes between 2 and 6 months to produce the reports, the data for these facilities will be a minimum of 18 to 21 months old at the time of publication.

According to CHFC management, existing statutes do not require facilities to report information based upon the same year-end dates. Nevertheless, the CHFC could reduce the age of its published data if it published some of its major

reports on a semi-annual rather than on an annual basis. Doing so would mean that the data for a major portion of the facilities would be approximately 12 months old by the time the last facilities filed their reports. Allowing 2 months for production of the report, the data for most facilities would be approximately 14 months old at the time of publication.

The CHFC Has Experienced Delays in Processing Health Facility Reports

Certain delays in the CHFC's processing system have contributed to the publication of reports in which annual data are not more current. Because not all of the computer programs used to process data for the most recent reporting period were prepared in time for processing health facility disclosure reports, there is a backlog of these reports. Furthermore, the CHFC has had a high turnover rate of employees responsible for processing disclosure reports. As a result of these conditions, the CHFC has had delays in processing disclosure reports; these delays also cause the data in CHFC publications to be less up-to-date than they could be.

In order to complete its yearly processing of approximately 600 hospital and 1,200 long-term care facility disclosure reports, the CHFC set a goal of processing at least 50 hospital reports and 100 long-term care facility reports

each month. The CHFC staff have not met the goal for the most current disclosure report period, 1980-81, resulting in a backlog of unprocessed reports and a delay in the publication of data. CHFC staff have yet to process almost 125 hospital disclosure reports and at least 1,100 long-term care disclosure reports, which means that the CHFC is about two months behind schedule for processing hospital reports and eleven months behind schedule for long-term care facility reports.

The CHFC's processing of hospitals' disclosure reports submitted for the 1980-81 publication periods has been delayed because the CHFC did not adequately plan for changing the computer programs used to process the data. The CHFC changed the format of both the hospital reporting forms and the CHFC publications that summarize the 1980-81 hospital data, and there were delays in developing the new computer programs. This situation delayed the processing of hospital reports until February 1982, a four-month delay. Although these problems are unique to the 1980-81 report period, the resulting backlog will continue to delay the publication of reports until that backlog is eliminated.

The high rate of employee turnover also contributes to the delays in processing all health facilities' reports. The CHFC has eleven full-time positions for conducting technical reviews of CHFC reports. Since 1981, the CHFC has

had to fill seven vacancies in these eleven positions with new employees. According to CHFC staff, these 7 positions remained unfilled for almost 3 months because of problems in the current classification requirements for accounting positions and because of delays in recruiting qualified employees. The State Personnel Board has recognized a problem with the current accounting classification. As a result, most of the current technical staff have been reviewing cost reports for only about 7 months. CHFC management state that it takes several months for the technical staff to learn the processing system and attain the expertise required to meet the established processing goals.

Outdated Data May Limit the Use of CHFC Reports

Because the CHFC does not collect timely annual data, data for a major portion of the hospitals and long-term care facilities in the CHFC reports are between one and one-half and three and one-half years old at the time of publication. Data this old are not always useful to health facility administrators and health planners. Table 3 shows the age of the data for the CHFC's major reports.

TABLE 3

MAJOR CHFC REPORTS AND AVERAGE AGE
OF HEALTH FACILITY DATA AT DATE OF PUBLICATION

Reports	Report Period	Average Age of Disclosure Report Data at Date of Publication for Approximately Approximately 40 Percent of Health Facilities[a]
Aggregate Hospital Data for California		
	6/30/78 - 6/29/79	23 months
	6/30/79 - 6/29/80	28 months
Individual Hospital Data for California		
	6/30/78 - 6/29/79	25 months
	6/30/79 - 6/29/80	28 months
Aggregate Long-Term Care Facility Data for California		
	12/31/78 - 12/30/79	36 months
	12/31/79 - 12/30/80	24 months
Individual Long-Term Care Facility Data for California		
	12/31/78 - 12/30/79	36 months
	12/31/79 - 12/30/80	24 months
Economic Criteria for Health Planning		
	1980	28 months
	1981-82[b]	
	Vol. I: Hospital	36 months
	Vol. II: Long-term care facilites	42 months

[a] Approximately 40 percent of the health facilities end their fiscal years within the first month of the CHFC collection period. The average age of data in the reports shown in this table for the other 60 percent of the facilities is between 17 and 36 months old.

[b] This is a draft report. The CHFC expects to publish the final report in June 1982.

Many health facility administrators and health planners reported that they do not use the information in CHFC reports because it is too outdated for policy and planning decisions. Of the 115 respondents who provided reasons why they either do not use CHFC reports or make only limited use of them, 78 (68 percent) stated that the information in the reports was too outdated. Specifically, 33 hospital and 36 long-term care facility administrators and 9 health planners from Health Systems Agencies and other public and private health agencies thought that the data were too old. We attempted to determine how current the data should be to be of most use to administrators and health planners. Of the respondents, 28 hospital and 35 long-term care facility administrators and 9 health planners stated that CHFC report data should be one year old or less to be useful for planning purposes. The following table summarizes respondents' answers to our question regarding the age of CHFC data.

TABLE 4

RESPONDENTS' OPINIONS ON USEFULNESS
OF DATA IN CHFC REPORTS
RELATIVE TO AGE OF DATA

	Respondents Finding Data Useful				
Age of Data	Hospital Administrators	Long-term Care Facility Administrators	Health Planners	Total	Percent
6 months	19	23	2	44	59%
12 months	9	12	7	28	38%
18 months	0	0	0	0	0%
24 months	1	0	1	2	3%
Total	29	35	10	74	100%

As the table indicates, 72 of 74 (97 percent) of the respondents to our question felt that the health facility data should be no more than 12 months old to be useful.

Need for Improved Planning for Research Efforts

The California Health and Safety Code gives the CHFC the authority to collect and publish information about health-care costs to help promote economy and efficiency in services provided by health facilities. In addition to publishing certain reports that are specifically mandated, the CHFC publishes other reports that provide and interpret data about health facilities. Although it is difficult to measure the total usefulness of these reports, some health planning

officials felt that some of these reports may be of limited use.* In our review, we identified ways in which the CHFC could improve its system for planning its annual activities and thereby help ensure that it is more responsive to the health-care research needs of the public and that it makes more efficient and effective use of its resources. During the audit, we reported our findings on this matter to CHFC officials, who agreed with our conclusions and have already taken steps to improve the CHFC planning system. Our findings dealt with three areas: identifying needs for health-care research, improving the CHFC's system for establishing workload priorities, and evaluating the effectiveness of the published reports in meeting the goals established by the Health and Safety Code.

Identifying Needs for Health-Care Research

The CHFC's current planning system could include a more formal means for the CHFC to solicit and consider ideas for health-care research topics that would be most useful to health planning and consumer groups. Currently, the CHFC prepares an annual workplan based on suggestions from CHFC

* These health planning officials included administrators of health facilities, employees of various government offices, including Health Systems Agencies and the Department of Health Services, health facility associations, and other individuals interested in health care information.

staff and technical advisory committees. The CHFC Advisory Council and CHFC staff members review and adopt the final workplan. However, this process does not ensure representation of all those individuals who use CHFC reports or could potentially use the reports but who have no direct connection to the CHFC or to members of the various CHFC committees.

According to the CHFC, both the CHFC itself and the Advisory Council are structured to represent the primary users of CHFC data. In addition, the CHFC maintains a network of technical advisory committees to advise the CHFC and staff on priorities, topics, and content of reports. The CHFC states that these committees provide valuable advice and suggestions on CHFC research activities. However, because it assumes that the individuals serving on the various committees and councils fully represent the interests of all users, the CHFC uses no formal process for soliciting direct participation on its proposed annual workplan from individual users outside the CHFC. Further, the CHFC maintains no formal record of the research requests that it has received throughout the year. The CHFC has attempted to assess the informational needs of users by soliciting comments on proposed research topics. This limited effort was successful in generating research topics, at least one of which was included in the CHFC workplan.

We conducted a telephone survey of eight Health Systems Agencies (HSAs) to determine whether the CHFC workplan, as revised at mid-year, reflects the research most useful to HSAs.* We focused on HSAs because they use CHFC data to assist them in planning health service needs. We developed a list of six projects and asked the HSAs to rank these projects according to their usefulness. Of the six projects, three were deleted from the workplan at the mid-year revision, two were added, and one was suggested by CHFC staff but not included in either the original or the mid-year plan.

The HSAs we surveyed ranked two of the projects deleted from the original workplan and the one project that had never been included in either the original workplan or the mid-year revision higher than one of the projects that was added at mid-year. Our limited test demonstrates that soliciting the opinions of those who will be using the information could assist the CHFC in establishing priorities for its projects.

* There are a total of 14 HSAs in California. We contacted the following HSAs: Northern California; North Bay; Alameda-Contra Costa; Santa Clara; Mid-Coast; North San Joaquin Valley; Orange County; San Diego and Imperial counties.

CHFC officials state that our review suggests some communication gaps exist in the CHFC's system for identifying the needs of those using CHFC reports. The CHFC therefore intends to increase its outreach effort by encouraging members of the Advisory Council and the technical advisory committees to contact those whom they represent to make them aware of opportunities to influence CHFC operations. The CHFC also plans to publicize the names of the members of the Advisory Council and the technical advisory committees as well as the interests they represent in the CHFC quarterly newsletter.

CHFC staff have indicated that they have also undertaken a variety of less formal efforts to assure the effectiveness and utility of the CHFC's research and disclosure activities. In preparing for the mid-year update of the 1981-82 CHFC workplan, the CHFC Research Branch sent written requests for research topics and priorities to the Office of Statewide Health Planning and Development, the Department of Health Services, and the members of CHFC advisory committees.

According to the CHFC, the staff of the Research Branch also telephoned representatives of the State's Health Systems Agencies and the Western Center for Health Planning to solicit ideas on research topics and priorities. In reviewing the report formats for the CHFC's annual hospital disclosure publications, staff sent written requests to at least 13 health

planning entities for suggestions on the content of the reports and the manner in which the data are presented. In addition, the CHFC has also indicated that in the future, it will solicit comments on proposed projects. By working closely with individual health planners as well as with individuals on CHFC committees and task forces, the CHFC may obtain information that is more pertinent to its proposed work.

The CHFC has taken steps to address the communication problems that exist between users of CHFC data and those who prepare the CHFC workplan. However, the CHFC should also implement a procedure to record and evaluate the results of its outreach efforts and any requests for research that it receives throughout the year.

Establishing Workload Priorities

In addition to considering the needs of users when establishing project workplans, the CHFC should examine the potential cost of projects and the staff resources that would be necessary to complete them. Our analysis indicated that the CHFC does not have adequate procedures to acquire this information. The CHFC's management information system does not include a method to calculate the costs of individual reports, including costs for data processing and for producing reports.

Also, because staff do not prepare outlines and establish objectives before developing project proposals, management may not be able to estimate accurately which projects can be completed within the year.

CHFC officials state that staff objectives and priorities are set or revised by the adoption and the mid-year update of an annual workplan that represents the priorities of the CHFC. CHFC officials further state that they intend to implement a more formal project planning process. Accordingly, the executive director has directed the Research Branch to develop procedures for project planning and monitoring to be adopted by all branch managers. These procedures will address such issues as project approach, methodology, and data requirements; proposed project schedule and completion date; and assessing the utility of the project compared to its anticipated benefits. These procedures will help the CHFC determine project priorities. However, because it does not currently have a means of identifying the cost of producing each report, the CHFC should also implement mechanisms to monitor the costs of its reports. To do this, the CHFC could assign each project an individual code to keep track of the production costs as well as the costs for staff and computer time for each project. The CHFC could expand its current time-reporting system to include these individual codes.

Evaluating the Effectiveness of Published Reports

One of the mandated objectives of the CHFC is to help promote efficiency and economy in the services provided by health facilities. As of the end of March 1982, however, the CHFC had neither measured the effectiveness of its reports in fulfilling this objective nor determined whether report data and formats are useful to health planning and consumer groups. Therefore, the CHFC cannot ensure that its reporting efforts are worthwhile. To remedy this problem, the CHFC should implement a system that measures the usefulness of its reports. In addition, the CHFC should develop an inventory system to identify the primary users of each report. For each report, this system should include a file with the original mailing list as well as the list of users who subsequently request and receive copies of the reports.

The CHFC states that during the past 18 months, it has improved its performance in assuring effective and economical disclosure of health-care data. As part of its project planning process, the CHFC will assess the effectiveness of each project in comparison to its anticipated benefits. The CHFC further states that this assessment will be presented to a project evaluation committee composed of key

CHFC managers, and the results of their evaluation will be presented to a technical advisory committee, to the Advisory Council, and to the CHFC.

In addition, the CHFC proposes to ask a random sample of those requesting CHFC reports for their assessment of a report's utility and contribution to the containment of medical costs. The CHFC is also examining the possibility of including a questionnaire in each CHFC report asking the reader to evaluate the publication according to specific criteria.

All of the above plans appear to be effective steps toward a more thorough evaluation of the benefit of CHFC reports. However, these improvements may not enable the CHFC to analyze the contribution of its projects in fulfilling the CHFC's mandated objectives. Although the CHFC proposes to ask users of its reports to evaluate them according to their usefulness in containing medical costs, the CHFC should also implement its own internal procedures to perform a similar evaluation.

Finally, because the users of CHFC reports may make valuable suggestions on the uses of the reports, the CHFC needs to develop guidelines for evaluating the responses from report users and from other health planning officials. These guidelines should identify areas where more information or

research would aid those who are in a position to promote economy and efficiency in providing health-care services. This review and evaluation process would also enable the CHFC to identify specific groups or individuals that are most likely to use the CHFC's research. The CHFC could subsequently work closely with these particular groups and individuals to develop topics for research.

CONCLUSION

The California Health Facilities Commission (CHFC) is responsible for collecting health-care information from California hospitals and long-term care facilities and making this information available to the public. Since its creation, the CHFC has developed and implemented standard accounting and reporting requirements for hospitals and long-term care facilities. Additionally, the CHFC has generally published, on time, specifically mandated reports. These reports provide information that was previously not available to health planners and consumers. The accuracy of the data submitted by health facilities is important to the use of reports by consumers and decision makers.

However, not all facilities have implemented the CHFC standard reporting and accounting requirements, and the CHFC has not established adequate procedures to ensure that the information it publishes is accurately prepared by health facilities and uniformly reported to the CHFC. Although it meets most of its publishing deadlines, CHFC could publish health-care information so that it is more timely; annual data in some CHFC publications are between one and one-half and three and one-half years old at the time of publication. Finally, the CHFC needs to improve its planning system to ensure that it publishes reports that are most useful to health planners and consumers. The CHFC has already begun to implement procedures to better plan for annual work activities. Because the CHFC does not ensure that certain data it collects and publishes are reliable and current, it may provide health planners and consumers with information that is of limited use in planning or promoting efficiency and economy in the provision of health-care services.

RECOMMENDATION

In order to ensure that health facilities are reporting accurate information, and that it collects data and publishes reports that are accurate and reliable, we recommend that the California Health Facilities Commission do the following:

- Develop a methodology for reviewing health facilities' implementation of the CHFC standard accounting and reporting requirements. There are at least three methods by which the CHFC could monitor facilities. First, the CHFC could consider entering into an interagency agreement with the Audits Branch of the Department of Health Services (DHS) to conduct reviews in those long-term care facilities and hospitals where DHS auditors conduct Medi-Cal audits. This method would require the CHFC to establish guidelines for DHS tests of health facilities. Second, the CHFC could develop self-audit techniques by which facilities review their operations and report to the CHFC on their implementation of the uniform reporting requirements. Finally, the CHFC could use its own staff to conduct limited tests at health facilities. This method would also help CHFC

staff identify reporting requirements that are subject to misinterpretation. The CHFC should evaluate the benefits and costs of these and other alternatives in seeking the best method to ensure that data are accurate.

- Establish procedures to ensure that the CHFC routinely revises and clarifies reporting requirements. Specifically, the CHFC could implement a method to track the frequency and pattern of the errors made on disclosure reports as well as the questions posed to CHFC staff by health facility administrators. The CHFC should also review the accounting and reporting manual to identify all changes necessary to meet the needs of the primary users of health-facility information. Finally, the CHFC should routinely solicit suggestions for revising or clarifying the system from health facility administrators and individuals who prepare the disclosure reports.

- Develop formal procedures to ensure that CHFC staff consistently interpret and instruct facilities on the requirements of the standard accounting and reporting system. The CHFC

should also determine if its staff members need formal training to improve their understanding of the accounting and reporting manual.

- Assess the need for and cost of training programs that would assist health facility staff in understanding the reporting requirements and in submitting accurate reports.

In order to ensure that it publishes data that are timely and most useful to health planners and consumers, the California Health Facilities Commission needs to collect health facility disclosure reports promptly and expedite the publication of its reports. Specifically, the CHFC should take the following actions:

- Encourage health facilities to file disclosure reports within the four-month filing period. The CHFC should routinely assess penalties against health facilities that submit disclosure reports after their deadlines unless justifiable cause is established.

- Ensure that its policy of reducing and waiving penalties is authorized by the Health and Safety Code. Further, the CHFC should develop strict

policies for reducing or waiving penalties. These policies should include a definition of "good and sufficient cause" that goes beyond the use of willful neglect as the sole criterion.

- Determine the feasibility of publishing some of the reports semi-annually or adopting other alternatives that will allow for publishing health-care data that is more up-to-date.

OTHER INFORMATION REQUESTED BY THE LEGISLATURE

The Supplemental Language to the 1981-82 Budget Act directed us to review the activities of the CHFC's Economic Criteria for Health Planning Committee (ECHP committee). Our review focused on the process it employed to develop the standards of effectiveness for long-term care facilities. This section of the report provides background information on the ECHP committee and the effectiveness standards, raises questions about the methodology the CHFC used to develop the standards, and provides the CHFC's response to those questions.

Background

The Health and Safety Code requires the CHFC to develop and submit to the Legislature an annual report on the standards of effectiveness for both hospitals and long-term care facilities; these standards are based upon health-care cost information that facilities submit to the CHFC. The code also requires that Health Systems Agencies consider these standards of effectiveness when preparing health plans for specific regions of California and for the State as a whole.

In response to the mandate to prepare standards of effectiveness, the CHFC formed a new advisory committee, the Economic Criteria for Health Planning Committee, to provide policy guidance to CHFC staff. To develop the standards of effectiveness for long-term care facilities, the ECHP committee appointed a task force of ten persons representing the long-term care industry, the public, and state government agencies. The committee charged the task force with determining the CHFC's authority to develop effectiveness standards for long-term care facilities, defining effectiveness in terms of cost efficiency and quality of care, identifying data needs for measuring effectiveness, determining the availability of such data, and preparing the standards themselves.

The report on effectiveness standards is due by March 1 of each year. However, the CHFC has not yet submitted its 1981-82 report to the Legislature because the CHFC did not begin developing the standards of effectiveness for the long-term care facilities until December 1980. The CHFC combined the 1981-82 and the 1982-83 reports into the one report, which is scheduled for approval by the CHFC in May and transmittal to the Legislature in June 1982. Basically, the standards of effectiveness for hospitals are based upon the overall costs of providing services, while the standards for

long-term care facilities are based not only on overall operating costs but also on the costs associated with some of the individual or structural components of health care such as nursing and dietary services.

According to the ECHP committee report, the task force chose to measure the effectiveness of long-term care facilities by considering the qualitative elements of care as well as the efficiency with which that care is provided. In doing so, the task force chose to evaluate each facility's overall performance for certain aspects of providing care to patients. In selecting possible standards of effectiveness, the task force was limited to using the existing CHFC disclosure report data base and the Department of Health Services' health facility licensing and certification records, which contained citations filed against facilities for violations of the Health and Safety Code. The task force determined that other available data were not adequate for establishing the standards.

The task force eventually selected ten standards that it felt reflected the environment in which long-term care facility patients receive care. Three of these standards measure the cost per patient day for dietary, laundry and linen, and housekeeping services. Five of the standards reflect the level of care provided directly to patients. These

include the per patient day cost of nursing services, the number of nursing hours per patient, the hourly wage for nurses, the employee turnover rate, and the percent of employees who have had 12 months of continuous employment. The remaining two standards, the per patient day cost of administrative services and the facilities' profit rate, reflect the financial management of the facilities.

Questions Regarding Effectiveness Standards For Long-term Care Facilities

In order to evaluate the standards of effectiveness for long-term care facilities, we reviewed the ECHP committee's draft report and questioned the methodology and criteria that the CHFC used to develop the standards. Certain conditions limited the CHFC's methodology in preparing the standards including limitations in the CHFC data base and constraints on staff time and resources. In addition to these limitations, our review raised questions about the assumptions the CHFC used in preparing the study, the quality control steps the CHFC conducted while preparing the report, and the ease with which health planners and consumers can interpret and use the standards. During our audit, we discussed these questions with CHFC officials. In responding to our questions, these officials clarified certain issues and shared our concern about others, many of which they hope to overcome as they improve the

standards in future publications. We cannot comment on whether the CHFC's proposed actions will resolve these questions. (See Appendix F for a detailed description of our questions and the CHFC's response.)

Assumptions Used in Study Methodology

Research methodologies generally require an individual to make certain assumptions regarding the subject being studied and the data upon which the assumptions are based. In preparing the standards of effectiveness for long-term care facilities, the ECHP committee task force and the CHFC staff made a number of assumptions. Our review raised questions about two of these assumptions.

First, in preparing the standards of effectiveness, the CHFC assumes that operating costs can be linked to the quality of care. Six of the standards are based on the assumption that a minimum level of expense is required to provide quality care to patients. For example, to meet the 1978-79 fiscal year standard for dietary services, a long-term care facility had to spend at least $3.33 per patient each day. Conversely, three of the other four standards assume that a facility should not exceed certain expenditure limits in providing adequate care to patients. The standard for administrative services, for example, is based upon the

assumption that a facility's average cost per patient day should be less than 15 percent of the overall operating costs per patient day.

In response to our question about this first assumption, the CHFC stated that the ECHP committee task force considered the qualitative aspects of care provided by long-term care facilities as well as the efficiency with which that care is provided. There are several approaches to measuring the quality of care, including the health of patients once they leave a facility and the types and amount of services provided to patients. Because the only data available to the CHFC concerned the costs of services provided, these costs were used as the basis for assessing the qualitative aspects of care. This approach was considered to be valid by the task force and was used in a study conducted by a university in another state. Finally, the CHFC notes that the standards for long-term care facilities were adopted unanimously by a task force representing a spectrum of California's long-term care community and that the standards have been endorsed by a number of organizations and individuals with direct interest in issues pertaining to long-term care facilities.

The second question we raised regards the CHFC's assumption that long-term care facilities and their patients are relatively homogeneous. In its report on hospitals, the

CHFC grouped hospitals into peer groups according to criteria such as size and complexity. Like hospitals, long-term care facilities may be affected by patient mix and geographical location; consequently, certain standards may not properly measure effectiveness. For example, facilities in geographical areas with high food costs may meet the $3.33 per patient day standard without being able to provide a nutritionally adequate diet for their patients.

According to CHFC management, the ECHP committee task force considered establishing long-term care facility peer groups on which to base the performance standards. However, because the task force believed that the patient population served by long-term care facilities is relatively homogeneous and that the services provided by those facilities were the same, it did not formally establish the peer groups. CHFC management agree that our concern about the potential geographic variations in the operating costs of long-term care facilities may be valid. The CHFC is currently considering ways of adjusting for such potential variations. CHFC officials state that as the CHFC gains more experience in using the effectiveness standards for long-term care facilities and as it gathers more data about long-term care facility operations, the standards will progressively become more sensitive to such factors.

Quality Control Steps
Used in Preparing the Standards

The ECHP committee standards of effectivenss for long-term care facilities are designed for use by health planners and consumers. Therefore, it is important that the CHFC use data that are accurate and reliable so that the standards themselves reflect accurate and reliable conditions. As part of our analysis of the CHFC's methodology for developing the standards, we reviewed the quality control steps that the CHFC used in preparing the standards.

According to the ECHP committee report, staff responsible for analyzing data and preparing the report performed two basic tests to verify that the data were accurate. First, the CHFC staff completed a full edit of approximately one-third of the facility disclosure reports. Next, the staff selected a 2 percent sample of disclosure reports and reviewed 17 data items reported by facilities. Since the ECHP committee report neither indicates whether these tests were based upon statistical analysis nor comments on whether the CHFC staff field-tested the variables, we asked the CHFC to clarify the procedures that staff used to ensure that the standards are based upon valid data.

According to CHFC management, staff tested the reliability of the data base by reviewing the accuracy of unedited disclosure reports. The CHFC reported that approximately one-third of the long-term care facility disclosure reports used in developing the standards had been fully edited by the CHFC accounting staff when the ECHP committee report was completed. Using a sample of 224 disclosure reports (a 20 percent sample), a separate study of the effects of the edit process for long-term care facility disclosure reports found that approximately 6 percent of the calculations used to compute the performance measures of the seven standards based on these data were affected by edit changes. As a result of these changes, the actual performance measured against the standards was changed in 2.6 percent of the cases sampled. The CHFC concluded that, in 97 percent of the cases of facilities whose data were unedited, the calculation of performance relative to the standards was correct. The calculations for facilities with edited data were 100 percent correct.

To further assess the accuracy of the data, the CHFC staff tested the reliability of the data entered into the CHFC computer by reviewing a 2 percent sample of the disclosure reports. Within these reports, all 17 of the data items used to calculate the standards were checked against the original form submitted by the facilities. The CHFC staff found a

100 percent match on these items; all items had been correctly entered into the CHFC computer. The CHFC staff concluded that to conduct further sampling would be an ineffective use of CHFC resources. However, it is not clear whether, in conducting their tests, the CHFC staff scientifically selected a sample of disclosure reports and variables that would predict the confidence rate of the data's accuracy. If in the future, the CHFC uses techniques based upon mathematical theory, it will predict statistically valid confidence rates for the CHFC data base.

Also, although the CHFC can ensure that it processes the disclosure reports accurately, the CHFC cannot ensure that health facilities report information correctly. Incorrect information reported to the CHFC may affect a facility's performance as measured against the established effectiveness standards. Similarly, the CHFC cannot ensure that the expenses reported to the CHFC are only for patient-related services. In the text of our audit report, beginning on page 11, we discuss in more detail the importance of the CHFC's ensuring that its data are accurate and that its accounting and reporting standards are appropriate to reflect only patient-related expenses.

Further, although field-testing is a common procedure used to ensure that research assumptions and data are accurate, the CHFC did not attempt to field-test in long-term care facilities any of the effectiveness standards. The CHFC did not conduct field-testing because public testimony in CHFC hearings from a number of organizations concerned with long-term care confirms that facilities' performance judged according to the CHFC's standards coincided with the assessments made by professionals assessing those facilities. Currently, the Senior Care Action Network in Long Beach has teams of nurses visiting long-term care facilities in the area to compare these facilities' performance as measured by the effectiveness standards with the nurses' professional assessment of the quality of care. The CHFC reports that it plans to incorporate the results of such assessments in its refinement of the standards and to undertake further "reality testing" of any future standards.

Before the CHFC uses this kind of testimony in developing effectiveness standards, however, it should first develop the policies necessary to ensure that the assessments are both uniform and accurate. Specifically, all evaluation teams should use the same criteria in assessing the facilities and uniformly report their assessments to the CHFC. Also, the

CHFC should develop a method of reviewing the procedures used by evaluation teams to ensure that data are prepared accurately.

Interpretation and Use of Standards

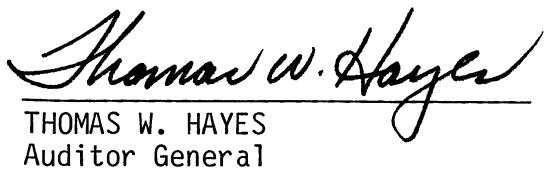
The ECHP committee report provides health care planners and consumers with information on how individual facilities rate according to each standard. The report, however, provides little indication about how a reader is supposed to interpret the results. For example, the report does not indicate whether certain variables are more critical to an evaluation of effectiveness than others. Also, a reader cannot determine if a facility that passes eight of the CHFC standards is more effective than a facility that passes only six or seven, regardless of which standards the facility fails.

According to CHFC officials, the standards are designed to give an interested person the basis for asking questions and making informed decisions about the performance of long-term care facilities. The ECHP committee report states as follows: "It is important to reiterate that one cannot conclude that a facility is doing a good, adequate, or poor job of providing care solely on the basis of the number of standards it meets. Reviewers of a facility should examine the facility's performance against each standard and determine

which factors are of concern." (Emphasis added.) The CHFC provides additional instructions for interpreting data on the standards in several sections of the report.

The CHFC states further that the ECHP committee task force deliberately chose ten unweighted factors upon which to base the standards; none of these were labeled as being "more central to an evaluation than others." It should be noted that the ECHP committee report gives the actual value for each facility's performance as measured by each standard so that a reader can determine by how much any facility met or did not meet a particular standard. Users of the report are encouraged to look at the individual standards in relation to the users' particular concerns. If a person is using the report as an aid in selecting a long-term care facility for a particular patient, that person should view the standards in relation to the patient's needs.

Respectfully submitted,



THOMAS W. HAYES
Auditor General

Date: May 14, 1982

Staff: Richard C. Mahan, Audit Manager
Kathleen A. Herdell
Kathleen L. Crabbe
Bernice D. Ericksmoen
Joni T. Low
Lois VanBeers

STATE OF CALIFORNIA

EDMUND G. BROWN JR., *Governor*

CALIFORNIA HEALTH FACILITIES COMMISSION
717 K STREET
SACRAMENTO, CALIFORNIA 95814
(916) 322-2810

May 12, 1982

Thomas Hayes, Auditor General
Office of the Auditor General
660 J Street, Suite 300
Sacramento, CA 95814

Dear Mr. Hayes:

This is in response to your report of findings on the review of the California Health Facilities Commission (CHFC). This response first provides a general discussion about the scope and focus of the audit and, second, discusses four more specific issues relative to the audit report.

General Discussion

In general, the Commission agrees with the major findings and recommendations presented in the report. In fact, the Commission has been aware of most of the opportunities for improvement which are presented in the report and has taken corrective action where possible within current resource constraints. However, the Commission is concerned that the audit report may leave readers who are not fully informed of the Commission's record of performance with an incomplete perspective of the Commission and its programs.

As you may know, the Commission welcomed a broad-based review of its activities - such as requested by the Legislature - and cooperated fully with your audit staff. Such a review held the promise of identifying real opportunities to improve the Commission's disclosure programs and of documenting the substantial progress made by the Commission over the past three years. While the audit report does note that the Commission has generally met its legislative mandates, most of the report focuses on: 1) the failure of some facilities to implement CHFC's uniform accounting and reporting systems and to report accurate data to the Commission based on these systems; 2) problems with the timeliness of certain CHFC summaries and compilations - problems largely inherent in the statutory structure of facility reporting requirements; and, 3) potential improvements in the planning of CHFC discretionary research reports.

The audit does not address the full range of Commission operations and, thus, does not provide a fully balanced picture of the Commission's performance. When the performance of the Commission with respect to implementing the statutory mandates of the Health Facilities Disclosure Act is considered, a perspective emerges that suggests that Commission operations are appropriate, effective, and vital to the effort to contain health facility cost escalation. These statutory mandates are listed below with a brief discussion of the Commission's effectiveness in meeting each mandate, including reference to your audit findings.

1. Establishment of Accounting and Uniform Reporting Systems

   The Commission has established uniform accounting and reporting systems as required by Section 441.15 of the Health and Safety Code. The hospital system was established in 1973 and the long-term care (LTC) facility system was established in 1976. As of January 1, 1981, the LTC reporting system was modified to accommodate a single uniform fiscal reporting document for use by both the Commission and the Department of Health Services (as required by Section 441.18 which was amended by SB 1370, Presley [Chapter 594, Statutes of 1980] to incorporate this requirement).

   Both the hospital and LTC systems are widely recognized as "state of the art" systems of accounting and reporting. The states of Arizona, Maryland, New York, and Washington have based their health facility accounting and reporting systems on the CHFC model. The federal Health Care Financing Administration used the CHFC system as the foundation for its Annual Hospital Reporting (AHR) system. We recently learned that National Medical Enterprises, a major proprietary hospital chain, is considering adopting the CHFC accounting and reporting system in all of its hospitals nationwide.

   While the CHFC accounting and reporting system may be the best in the nation, this is not to say that it cannot be improved. The audit staff did find several inconsistencies in the system manuals and identified the opportunity to improve CHFC interpretation and guidance to facilities with respect to the system manuals.

   The Commission has recognized these needs for several years and, in fact, has regularly requested additional staff to fill those needs. Each year, the Department of Finance has rejected these Budget Change Proposals.

A final point should be considered with respect to the uniform accounting and reporting system mandate: that is, the fact noted in the audit report that several facilities have not implemented the uniform system established by the Commission. This is a serious problem. While those preparing CHFC reports certify in writing under penalty of perjury that the reports are true and accurate and that the facility has implemented the Commission's uniform accounting and reporting system, this safeguard - the only routine safeguard authorized by the Legislature - has not proven fully effective. This affects the integrity of the CHFC data base, may affect Medi-Cal reimbursement policy, and undermines the legislative objectives and intent underlying the Health Facilities Disclosure Act.

Clearly, facilities themselves have a responsibility to comply with the requirements of the Disclosure Act. No degree of Commission oversight, regulation, and guidance can assure the complete accuracy and reliability of the data without the cooperation of the industry.

The audit report documents a problem suspected by the Commission for some time. This documentation will enable the Commission to pursue more aggressively the various alternatives for onsite compliance checks which are suggested by your audit staff.

2. Discharge Data Reporting

Section 441.18(g) of the Health and Safety Code (added by SB 1370) requires the development and implementation of a hospital discharge data reporting system. Working with a panel of experts in the field, the Commission's Patient Discharge Data Committee, the Commission has developed and is implementing the discharge data reporting system. Regulations have been prepared, along with a reporting manual. As of this date, we have received more than one hundred thousand discharge data records. Progress in implementing this system has been accomplished in spite of the lack of sufficient staff resources (a problem exacerbated by the current freeze).

The Commission's proposed budget for 1982-83 requests an increase of 22 percent, primarily for full implementation of this important program. This proposed expenditure has been reviewed and approved by the Department of Finance and the Legislative Analyst and is currently an issue of concern to various legislators. The report, unfortunately, does not addresss the real progress made toward implementing this important program.

3. Hospital Quarterly Reporting

Also added by SB 1370, Section 441.185 of the Health and Safety Code requires that the Commission collect and disclose within 105 days of the close of a calendar quarter certain hospital cost and utilization data necessary to monitor the effect of the California Voluntary Effort. This program was fully implemented on January 1, 1981, and the Commission has met the statutory deadline for publishing the data for every quarter. The Commission's quarterly reporting system provides the most current data on hospital costs available in the nation.

The Commission implemented this program with only one additional staff person by identifying various efficiency improvements in its data processing and disclosure systems.

Though your recommendations do not address the quarterly reporting program, it too could be improved. Limited by statute to twelve data items, the quarterly reports do not provide uniform statewide data on the physician professional component of hospital costs. Were such information provided, the quarterly data available from the Commission would be more useful, enable more reliable comparisons among individual hospitals, and provide valuable insight into the dynamics of hospital cost escalation.

4. Disclosure of Reported Information

Section 442 of the Health and Safety Code requires that the Commission make the data reported to it available for inspection upon the demand of any person.

The Commission meets this legislative mandate on a daily basis. In an average month, the Commission responds to data requests from approximately 250 individuals or agencies for 1,050 reports or publications prepared by the Commission. The most commonly requested items are the individual disclosure reports submitted to the Commission by health facilities. These data, while subject to the data accuracy concerns raised in your report, are available to the public approximately 120 days after the end of any facility's fiscal year end. The data are used by the facilities themselves, financial and legal institutions, private health systems management firms, consumer groups, and government agencies - including health planning organizations and medical care delivery programs.

Here too, however, improvements can be realized. Due to the large and increasing volume of requests for Commission data, telephone and written requestors often must wait three to

four weeks before their requests can be filled. To remedy this problem, the Commission has requested 1.5 additional staff, the cost of which will be largely offset by document sale revenues to the Commission. This request comprises a very small portion of the budget increase requested by the Commission for 1982-83.

5. Preparation of Summaries and Compilations

Section 442.1 of the Health and Safety Code requires that the Commission prepare and make available to the public summaries, compilations, and other reports of the data submitted by health facilities. The Commission's annual disclosure publications and special disclosure reports (e.g. the area studies) are prepared in response to this mandate.

As noted in your audit report, the information in these reports tends to be somewhat dated. This is largely a function of the statutory structure of health facility reporting as discussed in the second section of this letter. There are, nevertheless, opportunities to improve the timeliness of some of the Commission's published data, as noted by your audit staff. We intend to pursue such opportunities.

6. Annual Expenditure Estimates and Effectiveness Standards

Section 441.95, added in 1978 by SB 1903, requires that the Commission: a) estimate health facility expenditures for the state as a whole and for each Health Service Area (HSA); and, b) establish standards of effectiveness for all health facilities.

While the Commission has developed standards of effectiveness for hospitals and long-term care facilites, the complex process of developing and annually refining these standards has prevented the Commission from submitting a report to the Legislature by March 1 (as specified in Section 441.95) containing the expenditure estimates and effectiveness standards and formally approved by the Advisory Health Council.

The audit report makes no mention of the Commission's expenditure estimates or the hospital effectiveness standards. Rather, it discusses potential issues concerning the standards for long-term care facilities and the Commission's perspective on those issues. While this presentation is balanced, it does not address the value of this innovative effort.

7. Other Studies

Section 442.2 allows the Commission to undertake, with the approval of the Advisory Council, such other studies as it determines will advance the purposes of the Health Facilities Disclosure Act. Such studies are listed on page A-4 of Appendix A in the audit report.

While useful and informative, these research efforts comprise a relatively small portion of the Commission's total disclosure program. One of the major foci in your review of the Commission was on the process by which these discretionary research efforts are planned and completed. Here again, the Commission had already identified many of the deficiencies noted in your audit report and has initiated steps to remedy these problems.

8. Collection of Fees

Section 442.10 of the Health and Safety Code requires that the Commission set, charge to, and collect from all health facilities a special fee to support the operations of the Commission.

This fee, which amounts to 1.6 cents per patient day for LTC facilities and 7.3 cents per patient day for hospitals, has always been sufficient to cover fully all Commission operating expenses - General Fund monies have never been used to support the Commission. At the same time, because the Commission is highly cost-conscious with respect to its operations, it has taken full advantage of efficient new technologies such that it is not necessary to assess fees from facilities at the maximum rate allowed by Section 442.10.

Further, the Commission contracts with the Office of Statewide Health Planning and Development to collect on their behalf special fees from health facilities for support of health planning operations - a successful effort to eliminate duplication and maximize efficiency among state agencies in fulfilling their regulatory mandates.

Again, with respect to this mandate, improvements can be made, some of which have been identified by the Commission and are being pursued.

Specific Issues

This section address four specific issues which deserve additional attention: 1) data reliability; 2) costs and benefits associated with increased accuracy; 3) the Commission's limited audit authority; and, 4) structural factors affecting data timeliness.

First, regarding the issue of reliability of CHFC data, the report reaches no conclusion with respect to the effect that the identified accounting errors may have on the basic reliability of CHFC reports. For example, the errors in classification of expenses noted in your audit report do result in incorrect reporting of expenses by cost center; however, they may not result in any change in the expense per patient day for the provision of all services by the facility -- the bottom line. Notwithstanding the types of inaccuracies the audit staff have found, the Commission's data are as accurate as data in the facilities' own accounting records, are the best available in California (perhaps in the nation), and are reliable for use in health systems analysis, health planning, and health care policy deliberations. The report does not support an inference that the Commission's data are generally unreliable.

Second, the report does not specify the costs associated with improved enforcement and, thus, improved data reliability and does not compare those costs with the costs of decisions based on data that may be marginally inaccurate (the benefit to be achieved with the assurance of fully reliable data). As the audit report notes, while opportunities do exist for improving data reliability within current resource constraints, there is a point of diminishing returns; that is, a point where each dollar of expenditure to assure data accuracy results in less than one dollar's worth of benefit.

Third, the Commission has no authority to routinely inspect the books and records of a health facility. Section 441.19 of the Health and Safety Code provides that the Commission may undertake further examination of facilities records and accounts only "whenever, upon the recommendation of the executive director of the commission, and the approval, certified in writing, of a majority of commission members, a further investigation is deemed necessary or desirable to verify the accuracy of the information in the reports made by health facilities under this part ..." It has been the Commission's perspective that the Legislature did not intend that the Commission routinely inspect facility records and accounts to assure data reliability. With information such as that provided in your report and available in the audit staff working papers, the Commission may be able to exercise the authority granted by this section more aggressively.

Finally, the audit report does not discuss the fact that the statutory structure of health facility reporting requirements contributes to delay in publishing annual data summaries and compilations. Section 441.18 of the Health and Safety Code requires that each health facility report to the Commission within four months of the end of each facility's own fiscal year. Thus, if a report is prepared summarizing data from all facilities whose fiscal years end in calendar 1981, the

Commission does not receive all of the data for that report until May of 1982, when the facilities with a December 31 fiscal year-end date report. At that time, data from the facilities whose fiscal year ended in January of 1981 (and whose report was received by the Commission within four months of that date) is already fourteen months old. Additional time is required to verify the last reports received, prepare and proof the publication, and finally print and publish. Even if the Commission were to publish data on a semiannual basis, this structural delay would cause reported data to be about 14 months old. As noted in the audit report, this would not be sufficient to meet the users' needs for information not more than 12 months old.

Recognizing the structural delays inherent in the current statute, the Legislature established the hospital quarterly reporting mandate, which as mentioned above, provides the most current hospital cost data available in the nation.

In addition to structural delays in the preparation of summaries and compilations, the fiscal management decisions of state government affect the timeliness of publications. For example, when spending freezes were applied after the passage of Proposition 13, the Commission was not allowed to obtain the resources necessary to process and publish long-term care data. When the backlogged LTC data were finally fully processed and published in 1981, they were up to three years old.

In conclusion, as the discussion above suggests, when viewed from the perspective of its legislative mandates, the Commission has been both effective and efficient in its administration of the Health Facilities Disclosure Act. As with any operation as diverse and complex as the Commission's programs, opportunities for improvement do exist. The Commission itself has identified and taken full advantage of many such opportunities. Your audit report restates and confirms some of the problems known to the Commission but not fully resolved at this time. It also recommends several creative and valuable approaches to resolving these problems. The Commission intends to explore fully all of the recommendations you have made. However, these opportunities for improvement must be considered against a backdrop of successful and effective performance by the Commission, and the statutory and budget constraints as noted above.

Sincerely,

JOSEPH H. HAFKENSCHIEL
Executive Director

LIST OF CHFC PUBLICATIONS

Specifically Mandated Publications

The CHFC is required by law to publish the following three reports each year within specified deadlines.

Annual Report to the Governor and State Legislature of the State of California

This annual report presents a review of health care industry trends and CHFC activities. The report describes the CHFC and its history, presents characteristics of California's hosptial and long-term care facility industries, summarizes major CHFC activities in the past fiscal year, and describes the CHFC's work program for the current fiscal year. The "Annual Report" is available for the following years: 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, and 1981.

Economic Criteria for Health Planning Report (ECHP Report)

Prepared in accordance with Section 441.95 of the Health and Safety Code, these annual reports present standards for assessing the effectiveness of health facilities and estimates of health facility expenditures, in total and for the Medi-Cal program for each Health Systems Agency area (or health service area) and for the entire State. ECHP reports are available for 1979 and 1980.

Quarterly Financial Utilization Reports

The CHFC is also required to publish hospital data on a quarterly basis. Beginning in 1981, each hospital reporting to the CHFC has been required to submit information each calendar quarter for 12 specific data items related to hospital revenues, expenses, and utilization. This information is used to measure the effectiveness of the California Voluntary Effort, a voluntary program to limit operating cost increases. This information is entered into the CHFC's computer and a number of reports are produced. Although not as comprehensive as annual disclosure reports, quarterly reports provide up-to-date information on a number of key hospital operating characteristics. The following quarterly reports are available:

Facsimile Individual Hospital Report

This is a computer-generated facsimile of the Quarterly Financial and Utilization Report submitted by an individual hospital.

Summary Individual Hospital Report

These reports present quarterly financial and utilization data for individual hospitals for the current and the previous quarter and show the percent change. Data are also displayed for the current year to date and for the previous year. The report also includes calculated expenses, revenue, length of stay, and occupancy rate per day and per patient discharge.

Summary Statewide Report

This report presents statewide totals of quarterly financial and utilization data. Separate tables present the data for all hospitals statewide; all hospitals excluding Kaiser, State, dental, and Shriner hospitals; and each of the excluded groups of hospitals.

Individual Hospital Data

This report is a compilation of quarterly financial and utilization data by individual hospital within each of the State's 14 health service areas. Data for Kaiser, State, dental, and Shriner hospitals are displayed within health service areas.

Aggregate Hospital Data

This report presents a compilation of aggregate quarterly financial and utilization data arrayed by health service area, peer group (e.g., large teaching hospitals, large and/or more complex urban hospitals, and other groupings), type of control (nonprofit, investor owned, county/city, district, or university teaching), and for the State for all hospitals except Kaiser, State, dental, and Shriner hospitals.

Other Publications

Each California hospital and long-term care facility is required to submit an annual disclosure report within four months of the close of its fiscal year. The disclosure reports contain descriptive information about the facility including type of ownership, an inventory of services, related organization information, a balance sheet, long-term debt information, a statement of changes in equity, an income statement, a summary of revenues and costs by department, a

summary of revenues by payor, employee wage rates, and productive hours by employee classification and department. Once the CHFC processes the data, the Health and Safety Code authorizes the CHFC to publish reports to make this information available to the public. The following is a list of reports available for the hospitals and for the long-term care facilities individually, followed by a list of research and other reports available.

Annual Hospital and Annual Long-Term Care Facility Reports

Facsimile Reports (formerly Phase III Reports)

The original disclosure reports are reviewed by the CHFC's Accounting Branch and the data are entered into a computer. After the data have been edited to eliminate errors and after missing information has been added, a computer-generated facsimile of the disclosure report is produced. These Facsimile Reports are available either in printed form or on magnetic tape.

Summary Individual Hospital Reports; Summary Individual Facility Reports

After the original disclosure reports have been corrected and edited, and the data have been entered into the CHFC's computer, an Individual Summary Report can be generated. This report presents additional calculations and ratios not found in either the original or facsimile disclosure reports, such as revenue and expenses per patient day, and patient discharge and occupancy rates; distribution of employees; and patients' average length of stay.

Aggregate Hospital Data for California; Aggregate Long-Term Care Facility Data for California (formerly Inventory of Financial and Statistical Information for California Hospitals; Inventory of Financial and Statistical Information for California Long-Term Care Facilities)

This publication presents aggregate disclosure data analyzed by number of beds, health service area, and type of control.

Individual Hospital Data for California; Individual Long-Term Care Facility Data for California (formerly Hospital Data for Health Systems Agencies)

This publication presents disclosure data for individual facilities organized by Health Facilities Planning Area and health service area. For hospitals, the publication is presented in three volumes as follows:

Volume I: Northern California: Health Service Areas 1-8

Volume II: Los Angeles County: Health Service Area 11

Volume III: Central and Southern California: Health Service Areas 9-10 and 12-14

Research Reports and Special Studies

Consumer Guide to Health Care Costs

The Guide links health facility information received by the California Health Facilities Commission with data from other public and private agencies in order to present, from a consumer perspective, a broad overview of health-care cost containment issues. It also contains listings of federal, state, and local health agencies and consumer groups involved with health issues.

Research Reports

These reports utilize hospital disclosure report data to analyze selected health care issues. The following Research Reports are available:

A Comparison of Utilization and Costs in Kaiser and Non-Kaiser Hospitals in California: Presents a comparative study of Kaiser and non-Kaiser hospital costs and utilization patterns for the years 1970 to 1976.

A Statistical Summary of Gross Operating Costs for Long-Term Care Facilities in California, 1974-1978: Presents operating expense figures and percentage increases for long-term care facilities by health service area.

A Survey of the State-of-the-Art of Hospital Abstracting and Billing Systems in California: Summarizes results of a 1978 questionnaire completed by 561 California hospitals. Tables show the types of data processing systems hospitals use to process billing and data about patient discharges.

Capital Investment and Its Impact on Patient Costs in California Hospitals: Discusses the growth of capital expenditures and debt financing and the effect of these factors on operating expenses for various types of hospitals.

Changes in the Distribution of Costs Per Unit of Services Reported by California Hospitals Between the First and Second Disclosure Report Years: Presents a comparison of costs and revenues per unit of service between first and second reporting

years (1975-76 and 1976-77) for each hospital. Hospitals are grouped by location and complexity of service and are arranged from lowest to highest cost per unit of service for a variety of departments.

Changes in the Distribution of Costs Per Unit of Services Reported by California Hospitals Between the Second and Third Disclosure Report Years: Similar to the publication described above but covers the second and third disclosure years (1976-77 and 1977-78.)

Economic Standards for Health Planning in California--Working Papers: Report contains the nine research working papers that were prepared in developing the study entitled, "Economic Standards for Health Planning in California."

Indexes of Service Intensity and Service Price in California Hospitals, 1977: A study that demonstrates the relative effects of changes in service intensity, input price, wage rates, labor intensity, nonlabor prices, and nonlabor costs per patient discharged for 1977.

Trends and Projections for California Hospitals, 1972-1985: A study of California hospital cost trends from 1972 to 1976 with projections of total hospital costs through 1985, statewide and by health service area.

Cost Per Unit of Service in California Hospitals, Third and Fourth Reporting Periods, for Fiscal Year 1976-77 and Fiscal Year 1977-78: Presents summary cost data for California hospitals by peer group and cost center. Cost data are presented for both revenue and non-revenue producing departments, including adjusted direct costs, number of hospitals reporting data, units of service, and percent increase in each of the above between the two years noted.

Area Studies

The Cost of Hospital Care in San Diego, November 1979.

Hospital Costs and Services in Orange County, 1975-1978, August 1980.

Hospital Utilization, Expenses, and Revenues in San Francisco (HFPA 0423), 1975-1978, January 1981.

Hospital Utilization, Expenses, and Revenues in Santa Clara County (HSA 7), 1975-1978, February 1981.

Hospital Utilization, Expenses, and Revenues in the Golden Empire Health Service Area (HSA 2), 1975-1978, February 1981.

Hospital Utilization, Expenses, and Revenues in Health Facilities Planning Area (HFPA) 925, Los Angeles, 1975-1978, June 1981.

Hospital Operating Expenses and Utilization in Six Metropolitan Areas in California, 1975-1981, October 1981.

NUMBER OF QUESTIONNAIRES SENT AND RESPONSES RECEIVED

	Questionnaires Sent	Responses Received	
		Number	Percent
Hospital Administrators	109	63	58%
Long-term Care Facility Administrators	209	101	48%
Government Health Planners	143	57	40%
Private Health Planners	80	18	22%
Labor Union Officials[a]	142	3	2%
Total	683	242	35%

[a] Some Labor Union officials indicated that this questionnaire was not relevant to their work.

RESPONDENTS' USE OF CHFC REPORTS[a]

Use of Report	Hospital Administrators		Long-Term Care Facility Administrators		Public and Private Health Planners		Total	
	Number	Percent[b]	Number	Percent[b]	Number	Percent[b]	Number[b]	Percent[b]
Number Responding	46	100%	38	100%	60	100%	145	100%
General Information	44	96%	34	89%	56	93%	136	94%
Rate Setting	6	13%	4	11%	5	8%	15	10%
Controlling Costs	10	22%	10	26%	9	15%	29	20%
Regulatory Function	4	9%	3	8%	14	23%	21	15%
Policy Decisions	8	17%	9	24%	20	34%	37	26%
Planning	22	48%	15	39%	30	50%	67	46%
Consulting	3	7%	2	5%	25	42%	30	21%
Other	2	4%	3	8%	6	10%	11	8%

[a] This appendix presents information on respondents' use of the reports that are relevant to their particular organizations. We discuss only hospital administrators' use of reports relevant to hospital operations and long-term care facility administrators' use of reports pertaining to long-term care facility issues. Responses from public and private health planners pertain to the use of both hospital and long-term care facility reports. The CHFC reports in this analysis are listed on page C-2.

[b] Because respondents could indicate more than one use for the CHFC reports, the number and percentage for uses do not equal the number of total respondents within each user classification or type of use.

In conducting our survey, we included the following reports to determine the primary uses by the repondents.

HOSPITAL REPORTS

Annual:

Facsimile, or Phase III Reports; Summary Individual Hospital Reports, or Series A Reports; Aggregate Hospital Data for California; Individual Hospital Data for California.

Quarterly:

Summary Individual Hospital Reports; Summary Statewide Reports; Aggregate Hospital Data; Individual Hospital Data.

Other:

Area studies for individual regions of the State; Consumer Guide to Health Care Costs; specific research reports.

LONG-TERM CARE FACILITY REPORTS

Annual:

Facsimile Reports; Summary Individual Facility Reports; Aggregate Long-Term Care Facility Data for California; Individual Long-Term Care Facility Data for California.

Other:

Consumer Guide to Health Care Costs; specific research reports.

REASONS THAT SOME ADMINISTRATORS AND HEALTH PLANNERS RESPONDED THEY DO NOT USE CHFC REPORTS OR MAKE LIMITED USE OF THEM

User of Report	Reason Given: Outdated Information		Data Misrepresented		Unusable Format		Inaccurate Data		Number of Respondents	
	Number[a]	Percent	Number[a]	Percent	Number[a]	Percent	Number[a]	Percent	Number	Percent
Hospital administrators	33	73%	11	24%	18	40%	16	36%	45	100%
Long-term care facility administrators	36	71%	7	14%	20	39%	19	37%	51	100%
Health planners	9	47%	6	32%	9	47%	11	58%	19	100%
Total	78	68%	24	21%	47	41%	46	40%	115	100%

[a] The total number of responses given is greater than the total number of respondents because each respondent could give more than one response to the question.

REASONS THAT ADMINISTRATORS AND HEALTH PLANNERS BELIEVE THE DATA IN THE CHFC REPORTS ARE INACCURATE

	Reason Given									
	Inaccurate Data Reported By Facilities		Inappropriate Change Made By the CHFC		Inadequate or Unclear Reporting Requirements		Other		Number of Respondents	
	Number[a]	Percent	Number[a]	Percent	Number[a]	Percent	Number[a]	Percent	Number	Percent
Hospital administrators	18	78%	6	26%	16	70%	5	22%	23	100%
Long-term care facility administrators	14	58%	6	25%	10	42%	6	25%	24	100%
Health planners	13	72%	1	6%	6	33%	11	61%	18	100%
Total	45	69%	13	20%	32	49%	22	34%	65	100%

[a] The total number of responses given is greater than the total number of respondents because each respondent could give more than one response to the question.

APPENDIX F

CHFC RESPONSE TO AUDITOR GENERAL'S QUESTIONS ABOUT THE DEVELOPMENT OF THE ECONOMIC CRITERIA FOR HEALTH PLANNING COMMITTEE'S STANDARDS OF EFFECTIVENESS

STATE OF CALIFORNIA

EDMUND G. BROWN JR., *Governor*

CALIFORNIA HEALTH FACILITIES COMMISSION
717 K STREET
SACRAMENTO, CALIFORNIA 95814
(916) 322-2810

April 23, 1982

Rick Mahan
Office of the Auditor General
660 J Street, Suite 300
Sacramento, CA 95814

Dear Mr. Mahan:

The purpose of this letter is to respond to the questions raised in your "Discussion Paper" concerning the Commission's report on Economic Criteria for Health Planning (ECHP), FY1981-82/FY1982-83. Attached is a detailed response to the seven specific questions raised concerning the long-term care (LTC) effectiveness standards portion of the report. I would also like to comment briefly on how LTC effectiveness standards were developed and the conceptual framework used to assess the effectiveness of long-term care facilities.

As you know, the ECHP report is prepared in response to legislation that requires CHFC to provide yearly expenditure estimates and effectiveness standards for the State's hospitals and long-term care facilities. The report was developed by staff in consultation with a fifteen member committee appointed by the Commission (a list of ECHP Committee members is included as Attachment 2.) In addition, the ECHP Committee appointed a ten member Task Force (a list of Task Force members is included in Attachment 3.) This Task Force met six times over a six month period to develop effectiveness standards which address the unique characteristics of the long-term care industry. Each of the ten standards recommended met with the unanimous approval of the Task Force members. The report was then heard and adopted by the ECHP Committee in its public meeting of July 29, 1981. Subsequently, after completing Volume 1 of the ECHP report (which addresses hospital effectiveness standards), the entire report - including the LTC effectiveness standards - was heard by the Commission's Advisory Council in its public meeting of December 17, 1981, and again heard and then adopted at its public meeting of January 8, 1981. The Commission itself heard and adopted the ECHP report in its public meeting of January 18, 1982. Clearly, this process provided many opportunities for experts in the field and the general public to provide input to the development of LTC effectiveness standards to assure their relevance and usefulness.

This year's report was the first to include effectiveness standards for LTC facilities. The LTC standards were developed by a task force composed of persons with expertise in many aspects of long-term care. Because the legislation mandating the ECHP report did not provide an interpretation of

"effectiveness", the first issue faced by the Task Force was to develop a meaningful and practical interpretation of the term prior to the development of LTC effectiveness standards. The Commission's effectiveness standards for hospitals focus on maximum allowable levels of cost per day, per discharge, and per outpatient visit. The Task Force felt such standards would be inappropriate for LTC facilities. To quote from the report:

> "One of the difficulties in developing effectiveness standards for long-term care facilities is that these facilities are reimbursed in a way that creates quite different incentives than those faced by hospitals. Hospitals are generally reimbursed on the basis of their costs or charges rather than on a fixed rate, ... The major purchaser of long-term care facility services in California is the Medi-Cal program which pays for about two-thirds of long-term care. Medi-Cal pays LTC facilities a fixed rate per patient day ... Since the amount of reimbursement per patient day is fixed, the reimbursement system may create the incentive to provide less services in order to reduce costs and maximize the difference between the fixed rate Medi-Cal pays per patient day and what it actually costs to provide these services ... For this reason, the Commission believed that effectiveness standards for long-term care facilities should encompass other dimensions in addition to cost." (Vol. II, page 1)

Thus, the Task Force considered the qualitative aspects of care provided by long-term care facilities as well as the efficiency with which that care is provided. There are several approaches to measuring the quality of care including health outcomes, the process of care, and the inputs of care provided to patients. Because the only data available to the Commission concerned the inputs provided, these measures were used as the basis for assessing the qualitative aspects of care. This approach was considered to be valid by the Task Force and has been used in other studies.

The Task Force set standards for ten aspects of long-term care. Six of the standards set minimum levels of input for specific areas of patient care. The remaining three include maximum allowable levels of administrative cost, citations, and profit. Two measures of employee turnover, one a maximum (turnover) and one a minimum (length of service), were developed to assess the stability and continuity of facility staffing.

As stated in the report, the standards developed by the Task Force are the first step in a developmental process and will be refined in future reports. In their present form, they have, however, received public endorsements from a number of associations and individuals involved with long-term care. Some of the organizations endorsing the standards include:

- California Association of Homes for the Aging
- United Neighbors in Action
- National Gray Panthers Access Task Force
- Department of Health Services, Licensing and Certification Division
- Department of Aging, Long-term Care Ombudsman Program
- Alameda-Contra Costa Health Systems Agency (HSA)
- Central California HSA
- North Bay HSA
- Citizens for Better Nursing Home Care

It is the belief of the Task Force and the Commission that the information contained in these standards will be valuable to individuals, planners, and organizations seeking to evaluate the effectiveness of California's long-term care facilities.

I would like to thank you for this opportunity to address your concerns regarding the ECHP report. I hope the information provided clarifies the issues you have raised.

Sincerely,

Joseph H. Hafkenschiel
Executive Director

Attachment 1

CHFC Response to Discussion Paper
Relating to Economic Criteria for Health Planning FY 1981-82/FY 1982-83

1. Is this report based on valid data?

This question addresses two issues, the accuracy of unedited data and the method used to check for data entry errors in the Long-term Care (LTC) data base. As noted in the Economic Criteria for Health Planning Report (ECHP) (Vol. II, page 12), approximately one-third of the LTC disclosure reports used in developing the standards had been fully edited by the CHFC accounting staff when the report was completed. This discussion paper questions the accuracy of the other two-thirds of the data. In a separate study of the effects of the LTC edit process using a sample of 224 third year disclosure reports (a 20% sample), it was found that approximately six percent of the calculations used to compute the seven standards based on these data were affected by edit changes. As a result of these changes, actual performance against the standards was changed in 2.6 percent of the cases sampled. We conclude that the calculation of performance relative to the standards for facilities with unedited data is correct for approximately 97 percent of those facilities. The calculations for facilities with edited data are 100 percent correct.

In checking for data entry errors, staff reviewed a two percent sample of the reports comprising the disclosure data base. Within these reports, all seventeen of the data items used to calculate the standards were checked against the original form submitted by the facility. A 100 percent match was found on these items leading staff to conclude that further sampling was not likely to be an effective use of Commission resources.

2. This report is based on the assumption that larger amounts of inputs used in patient care result in better quality of care. Is this assumption valid?

The LTC standards are not based on the assumption that ever larger amounts of inputs result in better quality care. Rather, the standards are based on the assumption that, in six crucial areas, a minimum level of input is required to provide quality patient care. The assumption that there is a minimum acceptable level of various "inputs" to care is affirmed by all parties involved with long-term care and is firmly established in State licensing law and regulations.

This part of the discussion paper also questions the statement that the LTC standards are "consistent with recent research completed at the University of Arizona." (Vol. II, page 7) The table below compares the variables measured by the standards to those used in the Arizona study.

Long-term Care Standards Report	Arizona Study*
Nursing Services Cost per Patient Day	Nursing Expenditures per Patient Day
Housekeeping Cost per Patient Day	Maintenance and Operations
Laundry and Linen Cost per Patient Day	Miscellaneous Direct Patient Care Expenditures
Dietary Cost per Patient Day	Patient Dietary Expenditures per Patient Day
Administrative Services Cost per Patient Day	Administrative Expenditures per Patient Day
Nursing Hours per Patient Day	Registered Nurse Hours per Patient Day
Per Hour Nursing Wage Rate	Nursing Wage Rate
Turnover Rate	No Comparable Variable
Percent of Employees with Twelve or More Months of Continuous Service	No Comparable Variable
Citations	No Comparable Variable
Return on Owners Equity	No Comparable Variable

* Greene, Vernon L. and Deborah J. Monahan, "Structural and Operational Factors Affecting Quality of Patient Care in Nursing Homes", College of Business and Public Administration, University of Arizona, p. 4-9.

As is readily apparent from the above table, the variables used in the Arizona study were the same as seven of the Commission's LTC effectiveness standards. The Commission's standards went beyond the Arizona study by addressing employee turnover, citations, and return on owner's equity.

The discussion paper questions whether the Arizona study is "accepted as valid throughout the long-term care community." The many long-term care experts involved in the development of the LTC effectiveness standards accepted the approach used in the Arizona study and underlying the LTC effectiveness standards. It is also important to note that the LTC standards were adopted unanimously by a Task Force representing a wide spectrum of California's long-term care community and that they have been endorsed by a number of organizations and individuals with direct interest in long-term care issues.

Finally, the discussion paper states that "The way you set several of your standards challenges this assumption." This statement is a result of the misinterpretation of the assumption underlying the standards. In the specific case cited, i.e., the administrative services cost standard, the Task Force set the standard to discourage diversion of resources from direct patient care to other areas of facility operation. Once again, the need for such a standard is brought about by the generally fixed reimbursement rate for LTC services. To set the level, "The Task Force chose a standard consistent with an industry accepted 'rule of thumb' that administrative services should be less than 15 percent of the individual facility's average cost per patient day." (Vol. II, page 18)

3. Why wasn't the data adjusted or reported in a way that accounts for factors influencing the cost of nursing home operations?

First, it should be noted that the nursing hours standard is "peer grouped" to adjust for the number of skilled nursing, intermediate care, and special treatment days provided by the facility.

Initially, the Task Force considered setting overall peer groups to measure performance against all the standards. However, because the patient population served by long-term care facilities and the services provided by those facilities are relatively homogenous, peer grouping was not pursued. Medi-Cal reimbursement policy is predicated on the expectation of this same kind of homogeneity. However, the point raised by the discussion paper about potential geographic variation in LTC operating costs may be valid. The Commission is currently considering various methods to adjust for such potential variation:

- We are analyzing facility performance relative to the standard in relationship to variables such as ownership type, license category, and percent of revenue received from Medi-Cal.

- We are considering the potential for redefining the standards in a way that would not be affected by regional cost variation (e.g., pounds of laundry per day rather than laundry expense per day).

- We are considering setting the return on equity standard differently for proprietary and non-profit facilities.

As the Commission gains more experience with the use of the LTC effectiveness standards and more data about long-term care facility operations, the standards will progressively become more sensitive to such nuances as those brought up in the discussion paper.

4. How do you know that the standards you selected reflect an appropriate level of care? Specifically, were any of the standards field tested?

To reiterate earlier sections of this response, the standards were not intended to establish the "appropriate" level of care for all facilities and patients. There is no way in which one set of standards could accurately determine an appropriate level for all such individual cases. Rather, the report provides a large amount of information so that government, planning agencies, individual consumers, and other users can ask the questions required to determine the "appropriateness" of care for their particular case.

The Commission did not field test the LTC standards. Since their development, however, public testimony has been received from a number of organizations concerned with long-term care confirming that the report of performance relative to these standards coincided with their experience with those facilities with which they were familiar. Currently, the Senior Care Action Network in Long Beach has teams of nurses visiting LTC facilities in that area in order to compare performance on the effectiveness standards with their professional assessment of the quality of care. The Commission plans to incorporate the results of such activities in its refinement of the standards and to undertake further "reality testing" of future standards.

5. How can a reader reach conclusions about the relative quality of a long-term care facility based upon this report?

The discussion paper raises concerns about the interpretation of facility performance relative to the standards. Specifically, it asks "...how a reader is supposed to interpret the results" and "Are some of the standards more central to an evaluation of effectiveness than others?" The standards are designed to give an interested person the basis for asking questions and making informed decisions relative to the performance of LTC facilities. To quote the report, "It is important to reiterate that one cannot conclude that a facility is doing a good, adequate, or poor job of providing care solely (emphasis added) on the basis of the number of standards it meets. Reviewers of a facility should examine the facility's performance against each standard and determine which factors are of concern..." (Vol. II, page 30) Additional instructions and caveats for interpreting data on the standards are provided in several sections of the report.

The Task Force deliberately chose 10 unweighted factors upon which to base standards, none of which were labeled as being "more central to an evaluation than others." It should be noted that the report gives the actual value for each facility's performance against the standard so that a reader can determine by how much any facility met or did not meet the standard. Users of the report are encouraged to look at the individual standards in relation to their particular concerns. If the report is being used to aid in the selection of an LTC facility for a particular patient, the standards should be viewed in relation to that patient's needs. For instance, laundry services may be particularly important if the patient is incontinent; nursing services would be crucial if the patient is immobile. HSA's and consumer organizations have developed their own approaches to using the report. North Bay HSA, for example, requires facilities applying for certificate of need to document their performance on all ten standards, explaining any below standard performance and citing corrective actions taken to improve in these areas, if necessary.

6. Will changes in facility performance result in improvement in the quality of care?

The discussion paper states, "There seems to be no guarantee that changes in expenditure levels will result in improvements in quality of care primarily because these expenditure levels were not correlated with any actual, direct measures of quality." The report does not guarantee that higher expenditures produce higher quality care because such a guarantee would be inappropriate. The report is, however, based on the assumption that performance relative to these standards does relate to quality of care. Therefore, if a facility did not meet a standard one year and met it the next, the Task Force believed that quality for the aspect of care measured by that standard would have improved.

The discussion paper also states, "Facilities that currently exceed the minimum level of the standard can reduce their expenditures to the minimum level, still pass the standard, and yet presumably provide lower quality of care." There are two major problems inherent in such a hypothesis. First, if a facility were to make such cutbacks, the likelihood is that profits, citations, and employee turnover would increase, thus causing the facility to decrease their level of performance on three of the standards. The second and more important consideration is that LTC facilities function in an environment influenced by many factors including licensing requirements, audits by government agencies and PSRO's, and scrutiny by a wide variety of public and private groups. To suggest that a facility or group of facilities would deliberately decrease the level of inputs they provide to direct patient care solely to "game" the Commission's standard while ignoring other influences seems improbable. Finally, it should be stated that, if a facility can reduce expenditures while maintaining an acceptable level of patient care, they should not be discouraged from doing so.

7. The report states that CHFC has plans to analyze and to refine these standards further. How can these standards be improved if you are limited to existing data bases?

First, as discussed earlier, there are several refinements to the LTC effectiveness standards that are currently under consideration using the existing LTC disclosure and citation data bases.

In addition, other data bases exist (e.g., census data) which may be analyzed to assist in the interpretation and further development of the LTC standards. As additional data bases relative to the effectiveness and quality of care provided by LTC facilities become available, the ECHP Committee will consider the use of such data in refining the standards. A statewide data base on patient characteristics and outcomes of care does not currently exist and the cost of establishing and maintaining such a data base would be substantial. However, as such data become available, the Commission will analyze its relevance to the LTC effectiveness standards and refine those standards as appropriate.

Finally, the "feedback loop" inherent in the structure of the ECHP Committee, Advisory Council and Commission (i.e., the fact that representatives of users of the standards have a direct and formal role in developing the standards) will provide ideas for improving those standards given available information.

CALIFORNIA HEALTH FACILITIES COMMISSION

ECONOMIC CRITERIA FOR HEALTH PLANNING COMMITTEE

List of Members

Rick Badger
Executive Director
Golden Empire HSA
827 - 7th Street, Suite 431
Sacramento, CA 95814
(916) 447-3201

Jose Carlos

Gordon R. Cumming

*Victor A. Garlin, Ph.D.

Holland P. Golec, M.U.P.
Office of Statewide Health
Planning & Development
1600 Ninth Street, Room 402
Sacramento, CA 95814
(916) 322-2714

Yoshi Honkawa
Vice-President for Government
and Industry Relations
Cedar-Sinai Medical Center
8700 Beverly Blvd., Room 2802
Los Angeles, CA 90048
(213) 855-5701

Lucy Johns

Gretchen Karnish, R.N.
Administrator
Kaiser Permanente Medical
Center
1425 Main Street
Walnut Creek, CA 94596
(415) 943-2295

Herb McRoy, Director
Governmental Relations
Saint John's Hospital and
Health Center
1328 Twenty-Second Street
Santa Monica, CA 90404
(213) 829-5511

Larkin Morse
California Hospital
Association
1021 - 12th Street
Sacramento, CA 95814
(916) 443-7401

Kay Moser, Chief
Center for Health
Statistics
Department of Health
Services
714 P Street, Room 1476
Sacramento, CA 95814
(916) 445-1010

*Chair

04/82

CALIFORNIA HEALTH FACILITIES COMMISSION

ECONOMIC CRITERIA FOR HEALTH PLANNING COMMITTEE

List of Members - Continued

Anne Murphy

Jerome L. Schwartz, Ph.D.

Barbara Paris
Hospital Council of So. Calif.
6255 Sunset Blvd., Suite 817
Los Angeles, CA 90028
(213) 469-7311

Isadore Weinstein
Health West Foundation
20500 Nordhoff
Chatsworth, CA 91311
(213) 700-2062

Principal Staff

Sandra Felderstein, Manager
Research Branch
California Health Facilities Commission

717 K Street, First Floor
Sacramento, CA 95814
(916) 323-7675

ML-ECP

LONG-TERM CARE TASK FORCE

Richard Ainsley	Central California Health Systems Agency Visalia, CA
Hellan Dowden	California State Council Service Employees International Union Sacramento, CA
Paul Goss	California Association of Health Facilities Sacramento, CA
Holland Golec	Office of Statewide Health Planning and Development Sacramento, CA
Pat Grosch	Nurse, Long-Term Care Facility Petaluma, CA
Judith Hardy	Orange County Health Planning Council Tustin, CA
Charlene Harrington	Aging Health Policy Center, UCSF San Francisco, CA
Tom Moore, Jr., Chair of Task Force	On Lok Health Services San Francisco, CA
John Williams	Nursing Home Operator Long Beach, CA
Bill Wright	Center for Health Statistics Department of Health Services Sacramento, CA

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
State Controller
Legislative Analyst
Director of Finance
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps