America's Essential Hospitals 2014 Characteristics Survey Documentation

I. Section 1. Contact Information

1. **Name** - Name of survey respondent
2. **Title** - Job title of survey respondent
3. **Phone Number** – Phone number to best contact survey respondent
4. **Fax Number** – Fax number to best contact survey respondent
5. **E-Mail Address** – E-Mail address to best contact survey respondent

II. Section 2. Hospital Information

1. **Fiscal Year Start Date** – Fiscal year start date for fiscal year ending in 2014
2. **Fiscal Year End Date** – Fiscal year end date for fiscal year ending in 2014
3. **Hospital(s) represented in this survey**
    a. **PDF Version.** Select the drop down box to select your state, followed by the organization. Check the "Data Included in Survey" box if the hospital is included in the FY2014 Survey. If an additional hospital is not included, use the "Add Row" box to add an additional hospital
    b. **Excel Version.** Use the state drop down box to select your state, then the organizational dropdown to select your organization. From there you can click on and select individual hospitals that are included in the survey. If you accidentally select an additional hospital, click on it again to deselect it. Click on the "Save" button to save your selection. If you have additional hospitals, please include them in the body of the email when submitting the survey.

III. Section 3. General Information

1. **Local/County Health Department Relationship:** Examples of a formal relationship with the local health department would include the hospital or health system serving as the local/county health department, having a contractual agreement with the local/county health department, or sharing personnel/resources.

   Examples of an informal relationship include the hospital or health system having regularly scheduled meetings or sharing information regularly.

2. **Your organizations ability to differentiate patients** who purchased through the insurance exchange or from other commercial patients
3. **Patient and Family Advisory Council** presence in your organization

4. **National Committee for Quality Assurance (NCQA) recognition** as a Patient-Centered Medical Home (PCMH)
    a. **Number of level one** recognized medical sites
    b. **Number of level two** recognized medical sites
    c. **Number of level three** recognized medical sites
5. **Number of patients that your hospital/organization has helped to enroll in:**
    a. **Medicaid** – number of patients your hospital has assisted to enroll in Medicaid
    b. **State Children's Health Insurance Program (SCHIP)** – Number of patients your hospital has assisted to enroll in SCHIP

IV. Section 4. Inpatient Utilization

1. **Medicaid births** – Total births paid for by Medicaid, excluding fetal deaths

2. **Inpatient Utilization by Payer Source**

For each payer, please combine fee-for-service and managed care utilization. For discharges (Column 1), please report the number of adult, pediatric, and neonatal discharges; exclude normal births.

For total inpatient days (Column 2), please report the number of adult and pediatric inpatient days; do not include days provided for infants born without complications, but do include those for their mothers.

A. **Medicare**
    1. **Medicare Discharges** – Includes Medicare fee-for-service and managed care (HMOs, PPOs, etc.) as part of Medicare, not Commercial Insurance
    2. **Medicare Inpatient Days** – Includes Medicare fee-for-service and managed care (HMOs, PPOs, etc.) as part of Medicare, not Commercial Insurance
B. **Medicaid**
    1. **Medicaid Discharges** – Includes Medicaid fee-for-service and managed care (HMOs, PPOs, etc.) as part of Medicaid, not commercial insurance
    2. **Medicaid Inpatient Days** – Includes Medicaid fee-for-service and managed care (HMOs, PPOs, etc.) as part of Medicaid, not commercial insurance
C. **Commercial Insurance**
    1. **Commercial Insurance Discharges** - including Blue Cross
    2. **Commercial Insurance Inpatient Days** - including Blue Cross
D. **Self-Pay**
    1. **Self-Pay Discharges** - excluding Charity Care
    2. **Self-Pay Inpatient Days** - excluding Charity Care
E. **Charity Care**
    1. **Charity Care Discharges** - attributed to patients adjudged to be unable to pay under your hospital's charity care policy and should not be including in self-pay or indigent care.
    2. **Charity Care Inpatient Days** - attributed to patients adjudged to be unable to pay under your hospital's charity care policy and should not be including in self-pay or indigent care.
F. **State or Local Indigent Care Program**

1. **State or Local Indigent Care Program Discharges** - including patients covered under a city, county, or state sponsored indigent care program, or those uninsured patients for whom you bill the city, county, or state.
2. **State or Local Indigent Care Program Inpatient Days** - including patients covered under a city, county, or state sponsored indigent care program, or those uninsured patients for whom you bill the city, county, or state.

G. **Other**
1. **Other Discharges** - with examples being workers' compensation, VA Care, and prisoner care
2. **Other Inpatient Days** - with examples being worker's compensation, VA Care and prisoner care

H. **Other Pay Categories** – other groups included within questions; Section 4, G1 and Section 4, G2

V. Section 5. Ambulatory Care

Outpatient Utilization by Payer Source.

For Column 1 (Emergency Department Visits), please include all visits to the emergency department, even for those outpatients who were subsequently admitted to the inpatient areas of the hospital.

For Column 2 (Non-Emergency Outpatient Visits), please include all clinic visits to a designated medical unit responsible for treating patients on an outpatient, non-emergency basis, both on the hospital campus and in neighborhood or satellite clinics. Ambulatory surgeries, which are operations performed on patients who do not remain in the hospital overnight, should also be included. If your system has public health departments and/or provides outpatient correctional care services as part of your system, please also include these visits.

Also include here home health service visits where care is provided in a patient's home. Observation services, where a nurse or other staff may monitor a patient on the premises to determine if an inpatient admission is necessary should also be included.

Please only include face-to-face encounters with a physician, nurse practitioner, registered nurse, or physician's assistant. If you are not able to break out face-to-face encounters, please provide your best estimate of face-to-face encounters only. Please do not include ancillary services (e.g., laboratory, diagnostic services).

For Column 3 (Referred Visits/Ancillary Visits), please report the total number of outpatient ancillary visits to each specialty unit of the hospital established for providing technical aid used in the diagnosis and treatment of patients.

Examples of such units are diagnostic radiology, EKG, and pharmacy. Types of services include drawing blood, collecting specimens, performing laboratory tests, taking X-rays, giving immunizations, and filling/dispensing prescriptions. Each appearance of an outpatient in each unit constitutes one visit regardless of the number of diagnostic and/or therapeutic treatments that the patient receives.

1. **Outpatient Utilization by Payer Source**
   A. **Medicare**
      1. **Medicare Emergency Department Visits** – Includes Medicare fee-for-service and managed care (HMOs, PPOs, etc.) as part of Medicare, not Commercial Insurance
      2. **Medicare Non-Emergency Outpatient Visits** – Includes Medicare fee-for-service and managed care (HMOs, PPOs, etc.) as part of Medicare, not Commercial Insurance
      3. **Medicare Referral/Ancillary Visits** – Includes Medicare fee-for-service and managed care (HMOs, PPOs, etc.) as part of Medicare, not Commercial Insurance
   B. **Medicaid**
      1. **Medicaid Emergency Department Visits** – Includes Medicaid fee-for-service and managed care (HMOs, PPOs, etc.) as part of Medicaid, not commercial insurance
      2. **Medicaid Non-Emergency Outpatient Visits** – Includes Medicaid fee-for-service and managed care (HMOs, PPOs, etc.) as part of Medicaid, not commercial insurance
      3. **Medicare Referral/Ancillary Visits** – Includes Medicare fee-for-service and managed care (HMOs, PPOs, etc.) as part of Medicare, not Commercial Insurance
   C. **Commercial Insurance**
      1. **Commercial Insurance Emergency Department Visits**, including Blue Cross
      2. **Commercial Insurance Non-Emergency Outpatient Visits**, including Blue Cross
      3. **Commercial Insurance Referral/Ancillary Visits**, including Blue Cross
   D. **Self-Pay**
      1. **Self-Pay Emergency Department Visits**, excluding Charity Care
      2. **Self-Pay Non-Emergency Outpatient Visits**, excluding Charity Care
      3. **Self-Pay Referral/Ancillary Visits**, excluding Charity Care
   E. **Charity Care**
      1. **Charity Care Emergency Department Visits**, attributed to patients adjudged to be unable to pay under your hospital's charity care policy and should not be including in self pay or indigent care.
      2. **Charity Care Non-Emergency Outpatient Visits,** attributed to patients adjudged to be unable to pay under your hospital's charity care policy and should not be including in self-pay or indigent care.
      3. **Charity Care Referral/Ancillary Visits**, attributed to patients adjudged to be unable to pay under your hospital's charity care policy and should not be including in self-pay or indigent care.
   F. **State or Local Indigent Care Program**
      1. **State or Local Indigent Care Program Emergency Department Visits** - including patients covered under a city, county, or state sponsored indigent care program, or those uninsured patients for whom you bill the city, county, or state.
      2. **State or Local Indigent Care Program Non-Emergency Outpatient Visits** - including patients covered under a city, county, or state sponsored indigent care program, or those uninsured patients for whom you bill the city, county, or state.

3. **State or Local Indigent Care Program Referral/Ancillary Visits** - including patients covered under a city, county, or state sponsored indigent care program, or those uninsured patients for whom you bill the city, county, or state.

G. **Other**
   1. **Other Emergency Department Visits** - with examples being workers' compensation, VA Care, and prisoner care
   2. **Other Non-Emergency Outpatient Visits** - with examples being worker's compensation, VA Care and prisoner care
   3. **Other Referral/Ancillary Visits** - with examples being worker's compensation, VA Care and prisoner care

H. **Other Pay Categories** – other groups included within questions; Question 1, G.1; Question 1, G.2; Question 1, G.3

On Campus vs. Off Campus Distinction

An ambulatory location is **on-campus** if they occupy a physical area immediately adjacent to the provider's main buildings, other areas and structures that are not contiguous to the main buildings, but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus.

Off-campus locations do not meet on-campus criteria.

2. **Ambulatory utilization** of answers included within Section 5, Question 1.
   A. **Explanation** of Question Ambulatory utilization

3. **Number of ambulatory care locations affiliated with your organization.**
4. **Ambulatory Care allocations**
   1. **Number of FQHC's included**
   2. **Number of FQHC Look-Alikes**
   B. **Total on-campus** ambulatory care locations
   C. **Total off-campus** ambulatory care locations

Federally Qualified Health Centers (FQHCs)

A **Federally Qualified Health Center (FQHC)** is an entity that:

(i) Is receiving Section 330 funding (as a community health center, migrant health center, health care for the homeless grantee, health services for residents of public housing grantee, or health schools, healthy community grantee

(ii) Is receiving Section 330 funding under contract with an existing FQHC (as a subgrantee)

(iii) Was treated by the Department of Health and Human Services as a comprehensive fully funded health center as of January 1, 1990. *A FQHC look-alike meets all the requirements for receiving Section 330 funding, yet does not receive funding from any Section 330 grants (i.e., has been certified as a `FQHC look-alike' under Medicare and Medicaid).*

5. **Non-Emergency Outpatient Visits**
   A. **Primary care visits** including internal medicine, general medicine, family practice and pediatrics
   B. **Specialty care** non-emergency outpatient visits
   C. **On-campus** non-emergency outpatient visits
   D. **Off-campus** non-emergency outpatient visits
6. **Admissions Originating in the organizations emergency department**
   A. **Emergency Department visits** that resulted in admissions
   B. **Total number of admissions** excluding hospital births or normal newborns

VI. Section 6. Unique Patient Count

1. **Unique/New Patient Count by Payer Source**

The overall ***Unique/New (unduplicated) patient count*** includes inpatient utilization, emergency department visits, non-emergency outpatient visits, referred visits, and ancillary services. Exclude normal birth newborns.

This is the number of patients that are seen during the fiscal year, with each patient being counted only once. If a patient made multiple visits during the year but changed insurance status between visits count them only once, classified under the insurance status from their last visit of the year.

A. **Medicare Unique Patient Count** – Includes Medicare fee-for-service and managed care (HMOs, PPOs, etc.) as part of Medicare, not Commercial Insurance
B. **Medicare Unique Patient Count** – Includes Medicare fee-for-service and managed care (HMOs, PPOs, etc.) as part of Medicare, not Commercial Insurance
C. **Commercial Insurance Unique Patient Count** - including Blue Cross
D. **Self-Pay Unique Patient Count** - excluding Charity Care
E. **Charity Care Unique Patient Count** - attributed to patients adjudged to be unable to pay under your hospital's charity care policy and should not be including in self-pay or indigent care.
F. **State or Local Indigent Care Program Unique Patient Count** - visits including patients covered under a city, county, or state sponsored indigent care program, or those uninsured patients for whom you bill the city, county, or state.
G. **Other Unique Patient Count** - with examples being workers' compensation, VA Care, and prisoner care
H. **Other Pay Categories** – other groups included within Question 1, G.1

VII. Section 7 Financial Characteristics

This section is applicable only if you provide **intergovernmental transfers (IGTs)**, **certified public expenditures (CPEs)**, or **provider taxes** associated with base Medicaid payments (i.e., non-DSH, non-supplemental Medicaid payments).

For questions in part A, only report data on non-Federal share funding related to base Medicaid payments.

Part A.

Intergovernmental Transfers (IGTs) are amounts transferred by public providers or local governments, by you or on your behalf, to the state to draw down federal Medicaid funds in the matching process. Provider Taxes are state taxes on health care providers that help finance the state share of Medicaid.

1. **Intergovernmental transfers (IGTs)** or provider taxes associated with base Medicaid payments (i.e., non-DSH, non-supplemental Medicaid payments) for fiscal year 2014
   A. **IGTs relating to Medicaid payments** (This amount should not be reported elsewhere in Section 7, even if your organization reports transfers as expenses or adjustments to revenue
   B. **Provider Taxes** that are related to base Medicaid payments

Certified Public Expenditures (CPEs) are certifications by public entities that they have expended funds on items and services eligible for federal match under the Medicaid program.

2. **Certified public expenditures (CPEs) relating to base Medicaid payments (i.e., non-DSH, non-supplemental Medicaid payments) for fiscal year 2014**
   A. **Total expenditures actually certified** for federal match purposes, including 100% of the cost, not just the non-Federal share
   B. **Total Payments received for CPEs**

Part B.

This section is applicable only if you provide intergovernmental transfers (IGTs), certified public expenditures (CPEs), or provider taxes associated with base Medicaid payments (i.e., non-DSH non-supplemental Medicaid payments).

For questions in part B, only report data related to Medicaid DSH payments.

Intergovernmental Transfers (IGTs) are amounts transferred by public providers or local governments, by you or on your behalf, to the state to draw down federal Medicaid funds in the matching process. Provider Taxes are state taxes on health care providers that help finance the state share of Medicaid. *For California hospitals, these amounts should reflect SB1100 Medicaid DSH payments.*

1. **Medicaid Disproportionate Share (DSH) payments in fiscal year 2014**
   A. **Total DSH payments before any deductions for IGTs or provider taxes,** including all funds, such as local subsidies, used as the non-Federal share of DSH payments for Medicaid matching purposes.
   B. **IGTs relating to DSH program only**, not reporting this amount anywhere else in the financial section (even if your hospital usually reports transfers as expenses or as adjustments to revenue)
   C. **Provider Taxes relating to DSH** program only

Certified Public Expenditures (CPEs) are certifications by public entities that they have expended funds on items and services eligible for federal match under the Medicaid program.

2. **CPEs relating to the DSH program in fiscal year 2014**
   A. **Total expenditures** actually certified for Federal match purposes, including 100% of costs, not just the non-Federal share
   B. **Total payments received for CPEs** related to Medicaid DSH payments

Part C

Supplemental Medicaid Payments.
States are permitted flexibility in setting payment rates for hospitals and other providers. Most of these payments are subject to regulatory **upper payment limits (UPL)** that limit payments by provider type. These payments are typically supplemental to the base Medicaid payment rates for hospitals or other services. They are not Medicaid **Disproportionate Share Hospital (DSH)** payments. Therefore, for the purposes of Part C, *do not include base Medicaid or Medicaid DSH payments.*

1. **Supplemental Medicaid payments in fiscal year 2014**
   A. **Inpatient hospital services** supplemental Medicaid payments in fiscal year 2014
   B. **Outpatient hospital services** supplemental Medicaid payments in fiscal year 2014
   C. **Graduate Medical Education (GME)** supplemental education payments in fiscal year 2014
   D. **Any other additional services** which supplemental Medicaid payments were received in fiscal year 2014
2. **Supplemental Medicaid payments in fiscal year 2014** – *Do not include DSH payments reported in part B. For California hospitals, the amounts reported in this question should reflect AB915, SB1732, and SB1100 Safety Net Care Pool (SNCP) funds*
   A. **Total supplemental Medicaid payments** before any deductions for IGTs or provider taxes, including all funds, such as local subsidies, used as the non-Federal share of supplemental Medicaid payments for Medicaid matching purposes
   B. **IGTs relating to supplemental Medicaid payments** in fiscal year 2014
   C. **Provider taxes relating to supplemental Medicaid payments** in fiscal year 2014
3. **CPEs relating to supplemental Medicaid payments in fiscal year 2014**
   A. **Total expenditures actually certified for Federal match purposes**, including 100% of the cost, not just the non-Federal share.
   B. **Total payments received for CPEs** related to supplemental Medicaid payments

Part D

For questions in part D, please report the amount of any lump sum appropriations for indigent care or grants specifically for patient care purposes from government sources at the Federal, State, County, City or any other level that have not been reported as of yet in Section 7 of this survey

1. **Federal Government** appropriations for patient care
2. **State government** appropriations for patient care
3. **County government** appropriations for patient care

4. **City government** appropriations for patient care
5. **Other government authority** appropriations for patient care

Part E

Charity Care is defined as the amount of care provided to patients who are determined to be unable to pay as a result of hospital-defined policies to offer services free of charge to individuals who meet pre-determined financial criteria.

1. **Total Charity Care charges**
   A. **Charity care charges** reported in Part E, Question 1, for Medicare patients
   B. **Charity care charges** reported in Part E, Question 1, for Medicaid patients
   C. **Charity care charges** reported in Part E, Question 1, for patients enrolled in the insurance exchanges
2. **Your Organization's definition for Charity Care**

Part F

Gross Patient Charges by Payer Source and Service Type – reporting gross charges for each payer serviced.

A. **Medicare**
   1. **Medicare Inpatient Charges** – Includes Medicare fee-for-service and managed care (HMOs, PPOs, etc.) as part of Medicare, not Commercial Insurance
   2. **Medicare Outpatient Charges** – Includes Medicare fee-for-service and managed care (HMOs, PPOs, etc.) as part of Medicare, not Commercial Insurance
B. **Medicaid**
   1. **Medicaid Inpatient Charges** – Includes Medicaid fee-for-service and managed care (HMOs, PPOs, etc.) as part of Medicaid, not commercial insurance
   2. **Medicaid Outpatient Charges** – Includes Medicaid fee-for-service and managed care (HMOs, PPOs, etc.) as part of Medicaid, not commercial insurance
C. **Commercial Insurance**
   1. **Commercial Insurance Inpatient Charges** - including Blue Cross
   2. **Commercial Insurance Outpatient Charges** - including Blue Cross
D. **Self-Pay**
   1. **Self-Pay Inpatient Charges** - excluding Charity Care
   2. **Self-Pay Outpatient Charges** - excluding Charity Care
E. **Charity Care**
   1. **Charity Care Inpatient Charges** - attributed to patients adjudged to be unable to pay under your hospital's charity care policy and should not be including in self pay or indigent care.
   2. **Charity Care Outpatient Charges** - attributed to patients adjudged to be unable to pay under your hospital's charity care policy and should not be including in self pay or indigent care.
F. **State or Local Indigent Care Program**
   1. **State or Local Indigent Care Program Inpatient Charges** - including patients covered under a city, county, or state sponsored indigent care program, or those uninsured patients for whom you bill the city, county, or state.

2. **State or Local Indigent Care Program Inpatient Charges** - including patients covered under a city, county, or state sponsored indigent care program, or those uninsured patients for whom you bill the city, county, or state.

G. **Other**
   1. **Other Inpatient Charges** - with examples being workers' compensation, VA Care, and prisoner care
   2. **Other Outpatient Charges** - with examples being worker's compensation, VA Care and prisoner care

Part G.

1. **Total amount** of Medicare Direct Medical Education (DME)
2. **Payments for medical education** received from your state Medicaid program
3. **Other payments** for medical education
   A. **Description** of other payments for medical education

VIII. Part 8 Patient Demographics

1. **Discharges by Sex**
   A. **Total** male discharges
   B. **Total** female discharges
   C. **Total** unknown discharges
2. **Discharges by Ethnicity**
   A. **Total** Hispanic or Latino discharges
   B. **Total** Non-Hispanic or Non-Latino discharges
   C. **Total** Unknown ethnicity discharges
3. **Discharges by Race**
   A. **Total** American Indian or Alaskan Native Discharges
   B. **Total** Asian Discharges
   C. **Total** Black or African American Discharges
   D. **Total** Native Hawaiian or Pacific Islander discharges
   E. **Total** White Discharges
   F. **Total** Other Discharges
   G. **Total** Unknown Race Discharges
4. **Discharges by Age**
   A. **Total** Discharges for Those Age 0 to 1 year
   B. **Total** Discharges for Those Age 2 to 18
   C. **Total** Discharges for Those 19 to 44
   D. **Total** Discharges for Those 45 to 64
   E. **Total** Discharges for Those 65 Years or Older
   F. **Total** Discharges for Those Whose Age is Unknown