



TOBY DOUGLAS
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

February 19, 2014

PPL: 13-010

To: ARTICLE 13 COUNTY ADMINISTRATIVE OFFICERS
ARTICLE 13 COUNTY HEALTH EXECUTIVES

SUBJECT: AB 85 Final Resolution Form – Article 13 Counties

Purpose

The purpose of this policy and procedure letter is to provide guidance to the Article 13 counties regarding the submission of the county's Final Resolution form to meet the provisions specified in Assembly Bill (AB) 85 (Chapter 24, Statutes of 2013).

Background

AB 85 allows counties to choose one of the two options below for determining the county's payments to the Family Support Subaccount:

- The 60/40 Formula approach redirects 60 percent of the 1991 health realignment funds and 60 percent of the county maintenance of effort.
- The County Savings Determination Process, which is a formula-based approach that measures certain county health care costs and revenues, and redirects 80% (70% in fiscal year (FY) 2013-14) of the savings realized by the county.

Counties submitted their tentative decisions by November 1, 2013 in accordance with Section 17600.50(b) of the Welfare and Institutions (W&I) Code.

Section 17600.50(b) of the W&I Code also requires counties to adopt a final resolution informing the State of their final decision to choose one of the above options by January 22, 2014.

Final Resolution Form

The Final Resolution form provides the mechanism for counties to notify the State of their final decision. This form is binding. However, counties choosing the 60/40 formula have a one-time option to submit a petition to the County Health Care Funding Resolution Committee pursuant to W&I Code Section 17600.60(d) to later pursue the County Savings Determination Process.

Additional information regarding the petition process will be posted on the AB 85 webpage by January 31, 2014.

<http://www.dhcs.ca.gov/provgovpart/Pages/AB%2085.aspx>

Please complete and return the form to:

Department of Health Care Services
Realignment Unit, MS 4519
P.O. Box 997436
Sacramento, CA 95899-7436

Should you have any questions, please contact Michelle Gibbons at (916) 552-8494 or AB85@dhcs.ca.gov.

Thank you,

Original Signed by Pilar Williams

Pilar Williams
Deputy Director, Health Care Financing

Enclosures:

- Final Resolution Form

cc's: On next page

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cc: Diane Cummins
Special Advisor
Department of Finance
915 L Street
Sacramento, CA 95814

Farrah McDaid Ting
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1100 K Street, Suite 101
Sacramento, CA 95814



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Final Resolution for Determining Payments to the Family Support Subaccount

In compliance with Section 17600.50(b) of the Welfare and Institutions Code, Article 13 Counties (which include, Fresno, Merced, Orange, Placer, Sacramento, San Diego, San Luis Obispo, Santa Barbara, Santa Cruz, Stanislaus, Tulare, and Yolo) must adopt a resolution by January 22, 2014 informing the Director of the Department of Health Care Services of the County’s final decision to choose either the County Savings Determination Process or the 60/40 formula option.

_____ County chooses the option selected below
County Name

to determine payments to the Family Support Subaccount:

County Savings Determination Process - The formula pursuant to Welfare and Institutions (W&I) Code, Section 17613.1. The County acknowledges that upon choosing this option, this determination method is final and not subject to change.

OR

60/40 Formula - 60 percent of the 1991 health realignment funds that otherwise would have been allocated to the county and 60 percent of the county maintenance of effort, pursuant to W&I Code, Section 17600.50(b)(2). The county acknowledges that upon choosing this option, this determination method is final. However the county has a one-time option to submit a petition to the County Health Care Funding Resolution Committee pursuant to W&I Code, Sections 17600.60 (d) (A) & 17600.60 (d) (B) to later pursue the County Savings Determination Process.

I hereby certify, under penalty of perjury, that I am the official responsible for informing the State of the above option in said county for determining its payments to the Family Support Subaccount.

_____ Date _____
County Official (Signature)

County Official Title