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

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

October 11, 2013

PPL: 13-004

TO: PUBLIC HOSPITAL COUNTY ADMINISTRATIVE OFFICERS
PUBLIC HOSPITAL COUNTY HEALTH EXECUTIVES

SUBJECT: UPDATED: AB 85 Historical Data Request and Submission of Signed Documents

Purpose

This policy and procedure letter is to provide updated guidance to the Public Hospital Health System counties regarding the submission of the county's historical data and signed forms to meet the provisions specified in Assembly Bill (AB) 85 (Chapter 24, Statutes of 2013).

Background

On October 1, 2013, the Department of Health Care Services (DHCS) released guidance to the public hospital counties regarding the submission of historical data and released an "information only" version of the data submission form. The data submission form and companion guide have since been updated and are being released for official use by the public hospital counties. These updated versions should be utilized in lieu of the documents released on October 1st. The changes are highlighted in the applicable sections below.

Data Submission Form

The data submission form has been updated to auto-calculate the historical amounts and percentages based on the data inputted by the public hospital counties. The counties will input data in the DPH Submission tab, which will feed data through Schedule 1 and Schedule 2 and return the historical percentages and amounts in Section 11 of the Data Submission tab.

Brief descriptions of additional changes are highlighted below:

Other Payments (1n)
This field was added under the managed care revenues section. Counties may use this field to report incentive payments and/or risk pool payments.

Imputed Low Income Health Percentage (11b)
This field was added to the Historical Amounts and Percentages section. This field is auto-calculated and does not require county input.

Historical Amounts and Percentages
This section is now auto-calculated based on the data entered in the input fields in the DPH submission tab and the data entered will flow through Schedules 1 and 2.

Schedules 1 & 2
These schedules have been added to auto-calculate the historical amounts and percentages. The data from the DPH submission tab flows through calculations on both schedules and the historical amounts and percentages are auto-populated in section 11 of the DPH submission tab utilizing data from Schedule 2. These schedules, do not require county input, however formulas can be traced to understand how the historical amounts and percentages are calculated.

Data Submission Guide
In the data submission guide, “Other Payments” (1n) has been added to the Managed Care Revenues in Section 1, along with a brief description of what is to be reported in this field.

The data submission guide has also been updated to reflect the inclusion of the Imputed Low-Income Health Percentage (11b) in the historical amounts and percentages.

Signed Forms

All AB 85 related forms (including the certification and tentative decision forms) requiring a signature from a county representative must be signed and mailed to:

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

Electronic copies of signed forms will not be deemed as an acceptable submission. Original signatures must be received. If the county has already submitted electronic copies of the signed forms, please mail a hardcopy as noted above.

A signed certification form should be submitted by the county in conjunction with the data submission by October 31, 2013. The county should submit a signed tentative decision form by November 1, 2013.

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

Thank you,

Original Signed by Pilar Williams

Pilar Williams
Deputy Director, Health Care Financing

Enclosures:

- Historical Data Submission Guide
- Historical Data Submission Form

cc: Diane Cummins
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AB 85 – Public Hospital Counties
Historical Data Submission Guide

The data requested in this guide is intended for the following counties:

Alameda	Contra Costa	Kern	Monterey
Riverside	San Bernardino	San Francisco	San Joaquin
San Mateo	Santa Clara	Ventura	

The data submitted will be used to calculate the historical percentages and amounts that will be applied annually to the county savings determination process for each county in accordance with Welfare and Institutions (W&I) Code, Section 17612.1. Please provide the data requested below for each of the historical fiscal years (FY) which are FY 2008-09 to FY 2011-12. The data must be submitted to the State by October 31, 2013, in accordance with W&I Code, Section 17612.3(c)(1).

All data provided must be submitted with supporting documentation such as the applicable pages from the Comprehensive Annual Financial Report. All source documents and starting amounts must be clearly identified in the submission of the supporting documentation. Please provide any additional revenues and costs that are applicable if not specifically requested below. The Department of Health Care Services (DHCS) reserves the right to request additional supporting documentation or clarification as needed to substantiate the data received from the county.

A signed certification by an appropriate county official (Auditor/Controller, CAO, or the Health Agency Director) must be submitted to DHCS attesting to the accuracy of the data submitted.

The term “county” refers to the county, as defined by Welfare and Institutions Code, Section 17612.2(u), inclusive of a county public hospital health system as defined in Section 17612.2(f) i.e., including a designated public hospital and its affiliated governmental entity clinics, practices and other health care providers that do not provide predominately public health services.

All data requested in this guide, except where explicitly stated otherwise, should exclude the following as applicable:

- Mental Health (MH),
- Substance Use Disorder Services (SU)
- Nursing Facility (NF),
- Medicare/Medi-Cal Dual Eligibles,
- Jail Health and
- Public Health Services

1. MEDICAL SERVICE REVENUES

Medi-Cal Fee-for-Service (FFS) Revenues

Report all revenues received for medical services billed to Medi-Cal by the county. Revenues should be reported (accrued) based on the date of service, not when the payment was issued or received. Include all outstanding claims that are expected to be paid, including those still pending eligibility but expected to be approved.

Medi-Cal Revenues include:

- Medi-Cal FFS,
- Medi-Cal Managed Care,
- Supplemental Payments for Medi-Cal Services,
- Co-payments received from Medi-Cal beneficiaries and
- Medi-Cal Disproportionate Share Hospital payments

Medi-Cal Revenues exclude:

- Non-federal share of Medi-Cal Certified Public Expenditure (CPE) payments
- IGTs for the non-federal share of Medi-Cal payments
- Related fees imposed on transfers
- Administrative or related fees, payments or transfers

1a. Inpatient FFS Payments

Inpatient FFS payments are estimated on an interim basis and settled based on the inpatient FFS costs in the Interim Rate Workbook (P14) multiplied by the applicable Federal Medical Assistance Percentage (FMAP). The county should note that P14 settlement data includes days and charges for dual-eligible claims, which will need to be excluded. Settlement data used in the P14 calculation should tie to days and charges from your audited Medi-Cal cost report with any subsequent paid claims where available. The county should base their FFS revenues on actual costing to the extent possible; however, because of delays with eligibility, counties may estimate amounts that are pending approval. The county should include amounts paid for “state only”. Supporting documentation for “state only” revenues could include remittance advices which can be calculated by days multiplied by the interim rate in effect at the time.

The following steps outline how to calculate total inpatient FFS revenue:

1. In the P14, first eliminate dual-eligibles' days and charges and associated payments. This is done on Schedule 1.1. Days and charges in the column labeled "Medicare/Medi-Cal Crossover Days (QMB+SLMB+), Col 3" should be deleted for this calculation.
2. Pick up the net Medi-Cal cost on the P14, Sch. 2.1., Step 1, line labeled "Net Medi-Cal Cost reduced by State Only and Medi-Cal Share of Cost Charges". Multiply this cost by the FMAP for the period (incorporating the different FMAPs during some FYs).
3. Add back the administrative day payments, Schedule 3, Step 3, line labeled "Estimated Admin day payments for cost report year".
4. Add back "state-only" payments. This is the state-only percentage on Sch. 2.1, Step 1 multiplied by Medi-Cal FFS days on Sch. 2.1, Step 1, then multiplied by the interim rate that you were paid for the period.
5. Add state-only payments for services included in uninsured costs for the P14. NOTE: The state-only percentage in the P14 is only for certain aid codes that were included in your Medi-Cal settlement.

1b. Outpatient Hospital FFS Revenues

Outpatient hospital FFS revenues can be calculated using paid claims data, based on the schedule of maximum allowable (SMA). Paid claims data should be based on date of service and tie to the hospital payments reported on your AB 915 claim. The county must add back the state-only percentage here as well, and the payments for any state-only services that have been included as uninsured costs.

1c. Federally Qualified Health Clinic (FQHC) Prospective Payment System (PPS) Revenues (Medi-Cal FFS (non-managed care) enrollees)

Medi-Cal FQHC payments for FFS enrollees will include the full PPS payments, excluding those for Medicare dual-eligible crossover (codes 002 and 020) visits. This would exclude wraparound/SB 1194 payments (codes 018 and 019). Total FFS PPS payments should come from paid claims, electronic remittance files or system reports. Wraparound payments are listed below under Medi-Cal Managed Care.

1d. Outpatient Non-Hospital Revenues

Outpatient non-hospital revenues include non-hospital (non-FQHC) clinics as well as home health agency services, therapy services, ambulance services, or any other non-hospital or non-physician provider types that are provided by the county and billed to Medi-Cal. Revenue should be based on accrued payments and may come from paid claims, system reports, or electronic remittance files.

1e. AB 915 (Hospital Outpatient Supplemental) (FFP only)

AB 915 is an additional hospital outpatient reimbursement for costs in excess of Medi-Cal FFS payments. The AB 915 revenues should be based on the county's AB 915 claim (updated if more recent information shows a different number). Do not include the nonfederal share CPE, report only the FFP.

1f. AB 959 (Non-Hospital Clinic Supplemental)

Similar to AB 915, the Centers for Medicare and Medicaid Services (CMS) has approved a state plan amendment (SPA) to reimburse public entity-owned clinics for costs in excess of Medi-Cal FFS payments. AB 959 claims have not yet been filed. AB 959 applies to non-hospital (non-FQHC) clinic costs and is effective October 2006. CMS has approved the cost report and claiming protocol, which is similar to the non-hospital clinic cost report used in the P14 filing. Medi-Cal costs in excess of Medi-Cal payments are claimable as CPEs. If applicable, counties may estimate the FFP to be received.

1g. Physician FFS Revenues

Physician revenues are based on Medi-Cal FFS payments under any physician provider number (including payments for non-physician practitioners) and any physician payments allocated from hospital FFS payments. The payments should be based on the costs reported in the Physician SPA claim on the P14. For FY 2008-09 and FY 2009-10, the county may include total payments based on the P14 costs (exclude psych and dual-eligible payments), which are on Sch. 2.1-A, Step 7 for inpatient payments, and Step 11 for outpatient and psych payments. For FY 2010-11 and FY 2011-12, the county may include total payments based on P14 costs (exclude psych and dual-eligible payments), which are on Sch. 2.1-A, Step 8. The county must account for any payments received or anticipated to be received, subsequent to the P14 filing. The county may base payments on paid claims plus any accrued unpaid claims still in process.

1h. Physician SPA Revenue (FFP only)

Physician and non-physician practitioner costs in excess of Medi-Cal FFS payments are reimbursed on a CPE basis and claimed under the Physician SPA. These costs are reported in the P14, Schedules 1B and 2.1-A. Reimbursement is calculated as uncompensated Medi-Cal FFS physician costs multiplied by the FMAP. The county should only report the FFP portion of the payment received. For FY 2008-09 and FY 2009-10, counties may include the unreimbursed cost of Medi-Cal inpatient services, which are calculated on P14 Sch. 2.1-A, Step 7, and the unreimbursed cost of Medi-

Cal outpatient services, which are calculated on P14 Sch. 2.1-A, Step 11. For FY 2010-11 and FY 2011-12 the county may estimate payments based on the unreimbursed cost of Medi-Cal inpatient and outpatient services as calculated on P14 Sch. 2.1-A, Step 8. Unreimbursed costs for physician psych and dual-eligible services are claimable under the Physician SPA, but should be excluded for these purposes.

Medi-Cal Managed Care Revenues

Medi-Cal managed care revenues may be paid on a fee-for-service basis, capitated (based on a per-member-per-month calculation), or by other methods. Counties may also receive performance incentives and/or risk pool payments. Intergovernmental transfer (IGT) funded supplemental payments (rate-range IGT, SPD-IGT) are accounted for separately under “supplemental payments”. The county must include any withheld performance incentives or other items for the period that might have been paid at a later date. If the county cannot break out payments by specific service, an allocation methodology may be applied and submitted with supporting documentation.

1i. Inpatient Revenues

Report any payments received from Medi-Cal managed care plans for inpatient services based on date of service, or for capitation, by month of coverage. Non-patient-specific payments, based on a contract period, may have to be allocated across FY if not aligned with the state FY. If this is the case, supporting documentation must be submitted. Revenue should be based on accrued payments and may come from paid claims, system reports or electronic remittance files.

1j. Hospital Outpatient Revenues

Report any payments received from Medi-Cal managed care plans for outpatient hospital services based on date of service, or for capitation, by month of coverage. Non-patient-specific payments are based on contract period and may have to be allocated across FY if not aligned with the state FY. Counties should include payments for hospital-based FQHCs. Revenue should be based on accrued payments and may come from paid claims, system reports or electronic remittance files.

1k. Outpatient Non-Hospital Revenues

Report any payments received from Medi-Cal managed care plans for any outpatient non-hospital services based on date of service, or for capitation, month of coverage.

This would include home health, non-hospital clinics including FQHCs, therapies, ambulance, etc. Non-patient-specific payments based on a contract period may have to be allocated across FY if not aligned with the state FY. Supporting documentation must be submitted. Revenue should be based on accrued payments and may come from paid claims, system reports or electronic remittance files.

1l. Physician Revenues

Report any payments received from Medi-Cal managed care plans for physician services, including non-physician practitioners, based on date of service, or for capitation, by month of coverage. Non-patient-specific payments are based on contract period and may have to be allocated across FY if not aligned with the state FY. Revenue should be based on accrued payments and may come from paid claims, system reports or electronic remittance files.

1m. FQHC Wraparound Payments

Wraparound payments are the supplemental payments issued by DHCS for FQHC visits. They are reconciled annually to account for the difference between the PPS rate per visit and amounts paid by the managed care plan. The county should report both the actual wraparound payments received (code 18 and 19) as well as the reconciliation amount due from DHCS. The amounts reported should match the amount per the FQHC reconciliation, updated for any subsequent information.

1n. Other Payments

Report any other payments that are not already addressed such as performance incentives and/or risk pool payments.

<u>Other Supplemental Revenues</u>

1o. Hospital Fee Managed Care Revenues

The hospital fee managed care component should be based on actual or estimated amounts for each historical FY. The amounts paid by the plans were per a predetermined allocation per FY. NOTE: The FY 2011-12 payments were incorrectly calculated due to budget changes, and the amount that the plans paid was only 92.5% of the amount due the DPHs. The FY 2012-13 payments will be increased by the additional 7.5%. In order to report the amounts for the appropriate period, report the full accrued amounts, adding up to $80m in FY 2011-12.

1p. SB 1732 Revenues (Capital Project Debt Reimbursement)

The county should report actual payments received for SB 1732. If the Medi-Cal percentage is estimated for initial payment and adjusted later, the amount calculated based on the updated percentage should be used as the payment amount.

1q. Rate-Range IGT Revenues (FFP only)

The county should report supplemental managed care rate-range IGT revenues at net for this calculation, which varies from how they are reported in the P14. The county should include both hospital and non-hospital payments, to the extent they were actually received by the health system as opposed to other entities. Net is calculated as the gross amount received by the health system, less the IGT paid that is used as the federal match, and less the state fee which is 20% of the IGT paid (the state fee became effective in FY 2010-11). Do not include the nonfederal share IGT, report only the FFP.

1r. Senior and Persons with Disabilities Intergovernmental Transfer (SPD-IGT) Revenues (FFP only)

The county should report SPD-IGT (also known as SB 208) revenues at net for this calculation, which varies from how they are reported in the P14. The SPD-IGT program became effective on July 1, 2011. The county should include both hospital and non-hospital payments. Net is calculated as the gross amount received by the health system under IGT-B, less both IGT-A (repayment to the state for part of the non-federal share of the base SPD rates) and the IGT-B nonfederal match put up by DPHs to fund the additional revenue over base rates). Because the payments are based on plan rate-year, the county should prorate amounts to represent the correct FY depending on what rate-year is applicable. The county should tie to the FY 2011-12 amount reported on the P14, less IGT-A and nonfederal match of IGT-B. The year used should be the “long-year 1” amount annualized to FY 2011-12, which means multiplying by 12/15 for Two-Plan counties. This program does not exist in COHS counties. Do not include the nonfederal share IGT, report only the FFP.

1s. Disproportionate Share Hospital (DSH) Revenues

The amount reported should account for the actual DSH received and anticipated reconciliations, less any amount attributed to excluded Medi-Cal and uninsured services (MH, SU and NF).

2. Medicaid Demonstration Revenues

2a. Coverage Initiative (CI) Revenues

Coverage Initiative revenues (under the 2005 Medi-Cal Hospital Uninsured Care Demonstration (MH/UCD) waiver) are based on costs calculated on the P14 multiplied by the applicable FMAP. Reimbursement to each county is limited to the federal allotment if costs are higher. The county should report the calculated FFP for actual costs from the P14, up to a maximum of the FFP of the allotment. This will require allocation of the allotment across FY as the program year ran from September 1 to August 31. If MH, SU or NF costs are covered by the program, those costs and associated revenues will have to be removed from the calculation. Revenues for counties that participated in the program will be reported for FY 2008-09, FY 2009-10, and the first 4 months of FY 2010-11. The amounts reported may be based on the costs from the P14 Sch. 2.1-A, Step 8 for FY 2008-09 and FY 2009-10, and Sch. 2.1-A, Step 7 for FY 2010-11 (first four months only).

The county should also report reimbursement for administrative costs allowable under Attachment J of the MH/UCD waiver Special Terms and Conditions (STC).

2b. Health Care Coverage Initiative (HCCI) Revenues

HCCI revenues (under BTR waiver) are based on costs calculated on the P14 multiplied by the applicable FMAP. Reimbursement is limited to the federal allotment if costs are higher. The county should report the calculated FFP for actual costs from P14 up to a maximum of the FFP of the allotment. If MH, SU or NF costs are covered by the program, those costs and associated revenues will have to be removed from the calculation. HCCI allotments for FY 2010-11 (DY6) through FY 2013-14 (DY9) are in the BTR STCs, Attachment G, Supplement 1. The amounts reported should be based on the costs in the P14 Sch. 2.1-A, Step 7 for FY 2010-11 (last 8 months only) and FY 2011-12, less any exclusions. FFP is calculated in Step 12.

The county should also report reimbursement for allowable administrative costs claimed under Attachment J.

NOTE: Attachment J for the Low Income Health Plan (LIHP) has not yet been approved. The county should estimate both costs and revenues.

2c. Medicaid Coverage Expansion (MCE) Revenues

MCE revenues are based on costs calculated on the P14, multiplied by the applicable FMAP for FY 2010-11. If MH, SU or NF costs are covered by the

program, counties should remove those costs from the calculation. The county may report the calculated FFP for actual costs from P14, Sch. 2.1-A, Steps 10 and 11. FFP is calculated in Step 12. For FY 2011-12, if the county chooses a CPE-based reimbursement, the county may use the calculated FFP for actual costs from the P14, Sch. 2.1-A, Step 12. If the county has chosen capitated rates, the county may use member months times the capitation rate times the FMAP, plus the FFP for costs of carved-out services that are still CPE-based (such as out-of-network ER and post-stabilization costs), while still excluding MH, SU and prisoners/county jail inmates.

The county should also report reimbursement for allowable administrative costs claimed under Attachment J.

NOTE: Attachment J for the LIHP has not yet been approved. The county should estimate both costs and revenues.

2d. Delivery System Reform Incentive Pool (DSRIP) (FFP only)

DSRIP revenues reported by the county should include the actual amount of DSRIP net payment for the applicable FY (gross payment less the IGT used to claim the payment). Do not include the nonfederal share IGT, report only the FFP.

2e. Safety Net Care Pool (SNCP) Revenues

The amount reported should account for the actual SNCP received and anticipated reconciliations, less any portion attributed to MH, SU and NF costs.

3. Uninsured Revenues

3a. Uninsured Patient Payments

The county should include actual uninsured patient payments made by or on behalf of uninsured patients (e.g. car insurance/third party liability). The county should include any third party payments reported on the P14 and updated to account for subsequent collections or accrued expected payments. The county may utilize, but is not limited to, hospital patient accounting or decision support systems to determine these payments. Payments for MH, SU or NF services should be excluded.

3b. Maddy Fund Revenues

Maddy Fund revenues are passed to counties from additional levies on judicial fines and penalties and are paid out by the counties to private physicians treating the uninsured on an emergency basis.

4. Hospital Fee Direct Grants

The initial 21-month hospital fee was for the period April 1, 2009 through December 31, 2010. Because grant payments were delayed, the county should prorate the total direct grant across the FYs it corresponded to by taking the total direct grant value and dividing by 21 (months). Multiply that amount by the number of months in the FY.

> For example, if the total direct grant value was $100, then for FY 2008-09, the calculation would be $100/ 21 * 3.

The county should report actual payments received. The full amount of the direct grant should have been received.

The county does not need to include the 6-month hospital fee, which ran January 1, 2011 through June 30, 2011, as it did not contain a direct grant component.

The current 30-month hospital fee runs from July 1, 2011 through December 31, 2013. Direct grant payments were made for the FY 2011-12 and FY 2012-13 periods. Payments are based on the amount of the fee actually collected, and should represent approximately 97% of the total amounts. The county should report amounts actually received (the 97%). The first few rounds of payments were further underpaid because the calculation was not adjusted for budget changes to the direct grant, but the later rounds were increased to make up the difference. There may be some mismatching of payments per remittance advices to the appropriate period, requiring an overall proration.

5. Other Payer Revenues

Other payer revenues include all other revenues received by the health system for its hospital services and other medical services provided. This will include all other payers (Medicare including dual-eligibles, private insurance, etc.). It should exclude revenues/payments for MH and SU services under any payer, but include revenues/payments for NF services provided to patients in <u>all</u> payer groups (including Medi-Cal-only and uninsured). The county should not include revenues that have been offset in the cost reporting process (i.e., in the cost report, cafeteria revenues are offset against cafeteria expenses). The county should include grants

and other non-operating revenues. The county should report revenues on an accrual basis for the appropriate year. The county may use paid claims, system reports or electronic remittance files for medical service billing, claims filed with grantors, and other accounting documents.

6. REVENUES FROM COUNTY FUNDING

Counties may have to apply an allocation to determine the amounts of health realignment funds used for Medi-Cal or uninsured care if the funding received is bundled with multiple funding sources. If an allocation is applied, supporting documentation, a written methodology and supporting calculations must be submitted, in addition to the amount reported on the data submission form.

All references to the historical allocation are referring to the allocation methodology submitted to the legislature and agreed upon by the Department of Health Care Services and the California Association of Public Hospitals, as reflected in SB 98 (2013). The historical allocation defined a methodology for determining the special local health funds, county general fund subsidy amounts, and one-time and carry forward amounts.

Health Realignment Indigent Care Percentage

The health realignment indigent care percentage is the county-specific percentage of the 1991 Health Realignment Funds used for indigent health services.

The county should not include their 1991 health realignment maintenance of effort (MOE) amounts when reporting data related to the health realignment amounts received and/or used to support health services to the indigent. The MOE will be reported separately. If the county does not account for their 1991 health realignment MOE amount and health realignment amounts separately, the county may apply an allocation methodology. A written methodology, supporting calculations and documentation must be submitted in addition to the amounts reported on the data submission form.

6a. 1991 Health Realignment funds from the State to the County

Provide the **total amount** of health realignment funds from the State **received** by the county for each FY. This amount should correspond to data published by the State Controller (see links below) and should not include the county's 1991 health realignment MOE amount. The funding should be reported using the allocation from the different accounts in the data submission form. Health realignment funds include the amounts allocated from the:

i. Sales Tax Account and Sales Tax Growth Account
ii. Vehicle License Fee Account and Vehicle License Fee Growth Account

If the county accrues health realignment revenues and expenditures on a 12 month period that is different than the State Controller's Office, the county must submit the documentation for the 12 month period that the realignment funds are based on.

> For example, SCO published realignment funds for FY 2011-12 is based on a year to date of August 16, 2011 – August 15, 2012 for sales tax, and July 16, 2011 – July 15, 2012 for vehicle license fees. If the county's FY 2011-12 realignment funds are not based on these dates, then the county shall submit documentation for the 12 month period that the realignment funds are based on.

The same accrual methodology should be applied for each historical year.

SCO links

FY 2008 - 09: http://www.sco.ca.gov/ard_payments_realign_fy0910_base.html

FY 2009 - 10: http://www.sco.ca.gov/ard_payments_realign_fy1011_base.html

FY 2010 – 11: http://www.sco.ca.gov/ard_payments_realign_fy1112_base.html

FY 2011-12: http://www.sco.ca.gov/ard_payments_realign_fy1213_base.html

6b. 1991 Health Realignment funds used for Indigent Health Services

Provide the **total amount** of health realignment funds **used** by the county to provide indigent health services (Medi-Cal and uninsured). Identify the amounts for the county entities listed below to provide indigent health. The county should not include the 1991 health realignment MOE used.

i. Public hospital system,
ii. Public clinics and
iii. Other health service providers

If any of the entities above receive a lump sum from the county each year that bundles multiple local funding sources, those entities may need to work with the county to identify how much of those funds come from realignment or apply an allocation methodology.

The health indigent care percentage will be calculated by dividing the sum of the amounts provided in 6b by the amount provided in 6a. In other words: 6b/6a.

In future years, this percentage will be applied to the actual amount of realignment available, and that resulting dollar amount will be used in the realignment formula for that year.

There is no explicit allocation methodology for determining the amount of this funding the public hospital system receives that is for indigent care and not for excluded services such as public health, MH, SU, NF, and jail health. Typically the entire amount received by the public hospital system should be counted unless it can be demonstrated that a portion of the amount goes to supporting services that are not subject to this formula. The county will need to provide documentation of the amount provided to the public hospital system.

If the county has any non-hospital clinics that receive realignment funds, those funds should also be included. Include any realignment that supports public clinic functions related to health services for the indigent (i.e. not public health functions). The county would submit the amount provided to the clinic, including supporting documentation.

Imputed County Low-Income Health Amount (County Subsidy)

6c. County General Fund Contribution (property tax, general county funding to hospital, etc.) received

Provide the **total amount** of county general purpose funds (county subsidy) **provided** to the county entities listed below for health services (not just indigent health services). These amounts should exclude MH, SU, public health, and jail health. This will be the starting number for the allocation methodology; that methodology will further identify the portion of these funds used for indigent health care services.

i. Public hospital system,
ii. Public clinics and
iii. Other health service providers

For public hospital system providers, this would be the subsidy received by the county. The amount should match the audited financials for the FY. If the public hospital system provider receives a lump sum from the county each year that bundles multiple local funding sources, the public hospital system provider will need

to work with the county to identify how much of those funds come from county general fund. If an allocation is applied, counties should submit a detailed written methodology, along with supporting calculations, and documentation.

Please note that this should include any funds used for services for dual-eligibles or NF services, since these will be prorated away as part of "other payer shortfall/longfall" under the detailed allocation methodology.

Special Local Health Funds (Tobacco Settlement Funds and Special Assessments)

The amount of special local health funds used in the redirection formula will be the sum of the tobacco settlement funds plus the amount of assessments and fees. The amount of tobacco settlement funds and assessments and fees, will be determined separately, and in future years will be applied in the formula as the greater of the actual amount used by the county (county designated public hospital, the affiliated governmental entities, and other providers) or the amount determined using the historical allocation.

Tobacco settlement funds and other assessments and fees are "restricted" if they have been earmarked for Medi-Cal and/or uninsured care only when appropriated within the county. If they are for a broader purpose, for example, to generally support the hospital system, or for any type of health care expense, then they should be considered "unrestricted." Restricted and unrestricted amounts should be reported separately as described below.

6d. County Tobacco Settlement funds available to the County

Provide the **total amount** of funds **available** to the county during the FY from the Master Settlement Agreement entered into on November 23, 1998 by the State and leading US tobacco product manufacturer provided to the county.

6e. County Tobacco Settlement funds used for Bonds and Securitization

Of the total available county tobacco settlement funds determined in 6d above, provide the total amount **used** for bonds and securitization.

6f. Restricted Tobacco Settlement Funds available to the County (including MH/SU)

Provide the **total amount** of tobacco settlement funds **available** to the county below, for all indigent health services, including any portion used for MH and SU. This amount should be net any costs of bonds and securitization.

i. Public hospital system,
ii. Public clinics and
iii. Other health services providers

6g. Restricted Tobacco Settlement Funds available to the County (excluding MH/SU)

Provide the **total amount** of tobacco settlement funds **available** to the county below, for all indigent health services, excluding any portion used for MH and SU. This amount should be net any costs of bonds and securitization.

i. Public hospital system,
ii. Public clinics and
iii. Other health services providers

6h. Unrestricted Tobacco Settlement funds available to the County

Provide the **total amount** of unrestricted tobacco funds **available** to the county, including those available for purposes other than health. This amount should be net any costs of bonds and securitization and should include any portion used for MH and SU.

i. Public hospital system,
ii. Public clinics and
iii. Other health services providers

6i. Unrestricted Tobacco Settlement funds available to the County

Provide the **total amount** of unrestricted tobacco funds **available** to the county entities below for health services. This amount should be net any costs of bonds and securitization and should exclude any portion used for MH and SU.

i. Public hospital system,
ii. Public clinics and
iii. Other health services providers

6j. Restricted Assessments and Fees available to the County (including MH/SU)

Provide the **total amount** of restricted assessments and fees **available** to the county below, for all indigent health services, including any portion used for MH and SU.

i. Public hospital system,

ii. Public clinics and
iii. Other health services providers

6k. Restricted Assessments and Fees available to the County (excluding MH/SU)

Provide the **total amount** of restricted assessments and fees **available** to the county below, for all indigent health services, excluding any portion used for MH and SU.

i. Public hospital system,
ii. Public clinics and
iii. Other health services providers

6l. Unrestricted Assessments and Fees available to the County

Provide the **total amount** of unrestricted assessments and fees **available** to the county, including those available for purposes other than health. This amount should include any portion used for MH and SU.

i. Public hospital system,
ii. Public clinics and
iii. Other health services providers

6m. Unrestricted Assessments and Fees available to the County for Health Services

Provide the **total amount** of unrestricted assessments and fees **available** to the county for health services, excluding any portion used for MH and SU.

i. Public hospital system,
ii. Public clinics and
iii. Other health services providers

6n. One-Time and Carry-Forward Revenues

One-time and carry-forward revenues are defined as revenues and funds that are not attributable to services provided or obligations in the applicable historical FY, but were available and utilized during the applicable historical FY by the public hospital health system. This should not include, for example, delayed or unexpected payments for services provided in years prior to the FY being reported for. Do not include hospital fee revenues, or any other revenues that would fall into other reportable categories in this data protocol. An example would be drawdown of

reserves, or funds which the county made available in previous years and gave the county public hospital health system discretion on when to use. Documentation should be provided showing the nature and source of these funds and demonstrating that they meet this definition.

COSTS

The county should report all Medi-Cal and uninsured costs for medical services consistent with the cost claiming protocols in the BTR STCs.

7. Medi-Cal Costs

7a. Inpatient FFS Costs

The county will report total inpatient FFS costs from the P14 prior to any payment offsets. For each FY, this may be determined from the P14, Sch. 2.1, Step 1, "Total IP Hospital Cost per Day," multiplied by the Medi-Cal "Contract" days; however, the P14 will have to be recalculated with dual-eligibles removed. P14 settlement data includes days and charges for dual-eligible claims, which will need to be removed for the realignment calculation. The county can remove duals on P14 Sch. 1.1, by deleting the days and charges in the column labeled "Medicare/Medi-Cal Crossover Days (QMB+SLMB+) Col 3". In calculating final payments, the settlement data used in the P14 calculation should match to the days and charges from their audited Medi-Cal Cost Report with any subsequent paid claims where available. For FY 2011-12, costs need to be based on actual accrued costing and include any estimates that are pending approvals for their FY 2010-11 P14. The county should include state only programs for those included in the Medi-Cal settlement data.

7b. Hospital Outpatient FFS Costs

Total hospital-based outpatient FFS costs (including hospital-based clinics) will come from the AB 915 claim. The county should update hospital outpatient FFS costs to account for any additional paid claims and for any changes to the cost-to-charge ratios since the filing of the claim. To the extent that Medicare dual-eligible crossover charges were included in the AB 915 claim, the county will need to exclude them.

7c. FQHC Medi-Cal Costs (non-managed care members)

The county will calculate FQHC costs using the cost claiming methodology used in the P14 if hospital based, or FQHC cost report cost per visit times Medi-Cal visits. If this information is not available in the P14, it will have to be calculated based on approved Medi-Cal FQHC visits. If the county has filed an FQHC cost report as part

of the Medi-Cal cost report, the calculation can be based on visits multiplied by the per visit rate.

7d. Non-Hospital Service Costs

The county will calculate Medi-Cal non-hospital clinic costs under methodologies used by the P14 for uninsured non-hospital clinic costs, in accordance with the Non-Hospital Clinic SPA. The county will calculate non-hospital (non-FQHC) clinic costs per the non-hospital clinic cost report: cost per visit times Medi-Cal visits, excluding dual visits.

The county will need to determine costs for other non-hospital services (home health, therapies, ambulance, etc.) by using an appropriate costing calculation. Cost reports should be used if available (e.g., home health agencies (HHA)).

7e. Physician Costs

The county will calculate Physician costs from the Physician SPA calculation on the P14 Sch. 1B, excluding duals and Medi-Cal Psych physician costs.

7f. Intergovernmental Transfers to Fund Private Entities

The county can include IGT costs if the county makes a transfer to fund the non-federal share of payments that go to another provider. Most counties do not make these types of IGTs.

<u>Medi-Cal Managed Care Costs</u>

7g. Inpatient Costs

The county can identify costs on the P14, Sch. 2.1, Step 2, Col. 2 (Cols. 2-2c for FY 2010-11). The amount should be the gross cost before payment offsets. For FY 2008-09 and FY 2009-10, inpatient and outpatient services are combined. MH, SU and NF services will have to be excluded if included here.

7h. Hospital Outpatient Costs

The county can identify costs on the P14, Sch. 2.1, Step 2, Col. 2 (Cols. 2-2c for FY 2011). For FY 2008-09 and FY 2009-10, inpatient and outpatient services are combined. MH and SU services will have to be excluded if included here. The P14 should include costs from hospital-based FQHCs and other hospital-based clinics (see 7k below).

7i: Outpatient Non-Hospital Costs

The county can identify non-hospital clinic cost per visit on the non-hospital clinic cost report and multiply by Medi-Cal managed care visits. These costs are not on the P14. Other county-provided costs to Medi-Cal managed care enrollees (HHA, therapies, ambulance, etc.) will have to be determined by the appropriate costing methodology. Cost reports should be used if available (HHA).

7j. Physician Costs

The county can identify costs for physician and non-physician practitioner services provided to Medi-Cal managed care enrollees using the Physician SPA methodology, by entering charges for Medi-Cal managed care patients. These costs are not on the P14.

7k. FQHC Costs

The county can identify FQHC costs using the cost claiming methodology used in the P14, if hospital-based, or FQHC cost report/non-hospital cost report cost per visit times Medi-Cal visits. If this information is not available in the P14, it will have to be calculated based on approved Medi-Cal FQHC visits. If the county has filed an FQHC cost report as part of the Medi-Cal cost report, the calculation can be based on visits multiplied by the per visit rate.

7l. Out-of-Network Costs (OON)

If the county receives payments for Medi-Cal managed care enrollees, the county may have to pay other providers for emergency services at other hospitals or for services not available at the DPH. These costs are not included on the P14 as costs; they are normally represented by being excluded from managed care revenues. In this submission, they should instead be reported not as a revenue reduction but instead as a separate cost type. The county will need to calculate outside services paid to other providers for capitated enrollees. Invoices paid for services during the FY will also need to be reported.

As additional MCE costs, counties should report for FY 2011-12 only the estimated IGT contribution to the MCE Out-Of-Network Emergency Care Services Fund under SB 335 (maximum $20m/year across all DPHs) which supplements out-of-network rates to private hospitals. If the contribution to the fund has not yet been billed, it should be estimated based on the best available information.

7m. Allowable Administrative Costs

If the county is capitated for Medi-Cal managed care enrollees, they may have administrative costs specific to managing capitated beneficiaries. If the county pays a third-party administrator (TPA) or has county health plan costs that they pay for managing the capitated beneficiaries, the county should include those costs. This would only apply if that cost is excluded from the cost to charge ratio calculations in the cost reporting.

8. Demonstration/Expansion Population Costs (CI/HCCI/MCE)

8a. Coverage Initiative (CI) Costs (including allowable admin)

The county can identify medical service costs on the P14. FY 2008-09 and FY 2009-10 are calculated on Sch. 1 for hospital-based services and on Sch. 4 for non-hospital services, and are summarized on Sch. 2.1-A, Step 8. FY 2010-11 costs are for the first 4 months only and are summarized on P14, Sch. 2.1-A, Step 7. MH and SU costs should be excluded.

Allowable administrative costs should be included here based on the administrative claiming under Attachment J of the MH/UCD STCs.

8b. Health Care Coverage Initiative (HCCI) Costs (including allowable admin)

The county can identify on the P14. FY 2010-11 and FY 2011-12 costs are calculated on P14 Sch.1 for hospital-based services, Sch. 4 for non-hospital services, and Sch. 5 for non-hospital MH and SU services. These costs are summarized on the P14, Sch. 2.1-A, Step 7. Use schedule 5 to exclude MH and SU costs.

8c. Medicaid Coverage Expansion (MCE) Costs (including allowable admin)

The county can identify MCE costs on the P14. FY 2010-11 and FY 2011-12 costs are calculated on P14 Sch. 1 for hospital-based services, Sch. 4 for non-hospital services, and Sch. 5 for non-hospital MH and SU services. These costs are summarized on the P14, Sch. 2.1-A, Steps 10 through 11E. Use schedule 5 to exclude non-hospital MH and SU services. For costs calculated on Schedule 1, the columns that should be included are: “LIHP Patients enrolled in another County's MCE program” (excluding MH), “MCE Patients enrolled in County's LIHP MCE program for Medical Services,” and “MCE Patients enrolled in County's LIHP MCE program for CPE Based Services.” Costs included on Sch. 4 that should be included are FQHC costs and other non-hospital costs (out-of-network emergency/contracted services, administrative costs, Ryan White services, etc.).

9. Uninsured Costs

All uninsured costs for medical services (excluding MH, SU and NF) provided by the DPH or paid for by the county should be included here. To the extent the county pays private providers for these services, the cost is the amount of the contractual payment for the uninsured (non-LIHP) only.

9a. Inpatient Costs

The county can identify these costs for services provided by the DPH on the P14. For FY 2008-09 and FY 2009-10, inpatient and outpatient services are combined and calculated on P14, Sch. 1. For FY 2010-11 and FY 2011-12, inpatient costs are calculated separately on P14, Sch. 1. If the P14 includes MH services for the uninsured, this may need to be recalculated to exclude them.

9b. Hospital Outpatient Costs

Hospital outpatient costs for services provided by the county are identified on the P14. For FY 2008-09 and FY 2009-10, inpatient and outpatient services are combined and calculated on P14, Sch. 1. For FY 2010-11 and FY 2011-12, outpatient costs are calculated separated on P14, Sch. 1. If the P14 includes MH services for the uninsured, this may need to be recalculated to exclude them.

9c. Outpatient Non-Hospital Costs

This includes any uninsured payments made to other providers (entities not part of the county public hospital health system), or costs claimed for non-hospital clinics. Prior to 2011, these costs were reportable on the P14 in Sch. 2.1, Step 4, and on Sch. 4, and Sch. 5 (MH). These costs are summarized on Sch. 2.1-A, Step 6, use schedule 5 to exclude uninsured MH and SU services. For FY 2011-12 these costs are all entered on Sch. 4 and Sch. 5 (MH). These costs are summarized on Sch. 2.1-A, Step 6. Use schedule 5 to exclude uninsured MH, SU and NF costs will need to be removed from the calculation. This may include payments made to non-public hospitals for uninsured services, e.g., under an MIA program.

9d. Physician Costs

The county's costs for uninsured physician and non-physician practitioners for services provided to the uninsured are identified on the P14, calculated on Sch. 1B and summarized on P14 Sch. 2.1, Step 4. In some cases (in particular, if a county makes contractual payments to non-employed physicians to treat the uninsured) such costs may be identified separately on Schedule 2.1, Step 4, based on an entire contractual amount rather than the cost-to-charge methodology in Sch. 1B.

9e. Maddy Fund Costs

Maddy Fund costs are per county records and are based on paid claims and administrative costs.

10. Other Costs

10a. Total Health System Costs

To calculate other-payer costs, the county will have to calculate total health system costs. This should equal the DPH plus any public clinics and other health services (including all MIA-related costs) that may not be reported on a P14 but are part of the health care system. This should track to the county's enterprise fund plus any general fund-related medical service cost centers (non-hospital clinic costs or services where Medi-Cal and other payers are billed (clinics, home health, etc.) or any costs for services provided to the uninsured), but excluding MH and SU for all payers. (Please note that does not include public health-related services.)

10b. Other Costs

Next, the county will subtract calculated costs under Medi-Cal and Uninsured above. The amount left is all "other costs".

10c. Non-allowable / non-billable / non-reimbursable costs under Medi-Cal Cost Report

Identify any non-allowable, non-billable and non-reimbursable costs that are either eliminated from the Medi-Cal cost report as an A-8 or A-8-2, or are classified as non-reimbursable on the cost report. The county should not include Attachment D costs that are added back on the P14, either through schedule 1A, directly on Schedule 2.1 or Schedule 4 like non-hospital clinics, and payments to providers for the uninsured. Non-allowable costs include things like RCE limitation adjustments, research expense, and patient transportation. Costs will likely be non-billable services or non-revenue producing areas. Non-reimbursable cost centers should include things like marketing activities and unused space in the hospital. They should not be revenue producing. These costs would not include physician billing costs or malpractice insurance, as these are included on Schedule 1B, as part of physician costs.

10d. Other Payer Costs

Subtracting "non-allowable costs" in 10c from "other costs" in 10b will arrive at costs from other payers (Medicare, dual-eligibles, commercial, etc., and extending to Medi-Cal-only NF and uninsured NF costs).

11. Historical Amounts and Percentages

The historical amounts and percentages below, will be auto-populated in the data submission form:

a. Health Realignment Indigent Care Percentage
b. Imputed County Low-Income Health Percentage
c. Imputed County Low-Income Health Amount
d. Imputed Gains from Other Payers
e. Imputed other Entity IGT Amount
f. Special Local Health Funds
    i. Restricted Tobacco Settlement Funds Percentage
    ii. Restricted Assessments and Fees Percentage
    iii. Unrestricted Tobacco Settlement Funds Percentage
    iv. Unrestricted Assessments and Fees Percentage

SUPPORTING DOCUMENTATION

Supporting documentation must be submitted to DHCS in order to substantiate all data provided in response to this data request. Sufficient supporting documentation would include the source data, a written methodology and supporting calculations (such as: excel files that show the calculations). DHCS reserves the right to request additional supporting documentation or clarification as needed to substantiate the data provided by the county.

Source Data

Source data contains the original amounts prior to any allocation methodologies or calculations being applied. For example, the county allocations of health realignment published on the SCO's webpage would be considered a source data as it contains the original amounts provided by the State to the county.

Written Methodology

A written methodology would be submitted for any amount reported that required the county to perform a calculation on the source data. The written methodology must guide the reviewer through the calculation performed and explain why the calculation was needed, including any assumptions that were made.

Supporting Calculations

Supporting calculations should contain formulas or steps that were performed in the allocation methodology allowing the reviewer to follow each step that was performed, starting with the original source data amount to the final amount that is report on the data submission form.

EXAMPLES OF SUPPORTING DOCUMENTATION

- Comprehensive Annual Financial Report
- SCO published reports
- Contracts
- Chart of Accounts
- General ledger for expenditures and revenue by fund account
- Bridging documents maintained by program or accounting staff (e.g., Excel tracking spreadsheets)
- Expenditure reports for each FY
- County Budgets
- County Adhoc Reports
- Remittance advices

- Paid Claims reports
- Invoices
- Hospital and Clinic Cost Reports (e.g. P14 workbooks or Medicare cost report)

AB 85 Public Hospital County Data Submission Form

Counties only need to input data in the gray cells in this tab (row 6 select county name and rows 11 through 137).
All other tabs in this workbook are auto populated by the information from the gray cells below.

Data inputed required

Select County from List					**Select County from List**			
Items from companion guide				**REVENUE OR COST**	**FY 2008-09**	**FY 2009-10**	**FY 2010-11**	**FY 2011-12**
REVENUES			**Data Source**	***All revenues and costs unless otherwise noted Excludes Nursing Facilities, duals, mental health, and substance use disorder services) * All revenues should be net of any IGT or CPE (represents FFP only)**				
1	**Medi-Cal Revenues**							
	Medi-Cal FFS Revenues							
	1a		P-14	Inpatient Fee for Service (FFS) Payments	$ -	$ -	$ -	$ -
	1b		P-14	Outpatient Hospital FFS Revenues	$ -	$ -	$ -	$ -
	1c		P-14	FQHC PPS Revenues	$ -	$ -	$ -	$ -
	1d			Outpatient Non-Hospital Revenues	$ -	$ -	$ -	$ -
	1e		P-14	AB 915 (OP Hospital Supplemental), FFP Only	$ -	$ -	$ -	$ -
	1f			AB 959 (Non-Hospital Clinic Supplemental)	$ -	$ -	$ -	$ -
	1g		P-14	Physician FFS	$ -	$ -	$ -	$ -
	1h		P-14	Physician SPA FFP Only	$ -	$ -	$ -	$ -
	Medi-Cal Managed Care Revenues							
	1i		P-14	Inpatient Revenues	$ -	$ -	$ -	$ -
	1j		P-14	Hospital Outpatient Revenues	$ -	$ -	$ -	$ -
	1k		Other	Outpatient Non-Hospital Revenues	$ -	$ -	$ -	$ -
	1l		Other	Physician Revenues	$ -	$ -	$ -	$ -
	1m		Other	FQHC Wraparound Payments	$ -	$ -	$ -	$ -
	1n		Other	Other Payments	$ -	$ -	$ -	$ -
	Other Supplemental Revenues							
	1o		P-14	Hospital Fee Managed Care Revenues	$ -	$ -	$ -	$ -
	1p			SB 1732 Revenues	$ -	$ -	$ -	$ -
	1q		P-14	Rate Range IGT Revenues, FFP Only	$ -	$ -	$ -	$ -
	1r		P-14	SPD-IGT Revenues FFP Only	$ -	$ -	$ -	$ -
	1s		P-14	Disproportionate Share Hospital (DSH) Revenues	$ -	$ -	$ -	$ -
2	**Medicaid Demonstration Revenues**							
	2a		P-14	Coverage Initiative (CI) Revenues	$ -	$ -	$ -	$ -
	2b		P-14	Health Care Coverage Initiative (HCCI) Revenues	$ -	$ -	$ -	$ -
	2c		P-14	Medicaid Coverage Expansion (MCE) Revenues	$ -	$ -	$ -	$ -
	2d			Delivery System Reform Incentive Pool (DSRIP), FFP only	$ -	$ -	$ -	$ -
	2e		Other	Safety Net Care Pool (SNCP) Revenues	$ -	$ -	$ -	$ -
3	**Uninsured Revenues**							
	3a			Uninsured Patient Payments	$ -	$ -	$ -	$ -
	3b			Maddy Fund Revenues	$ -	$ -	$ -	$ -
4	**Hospital Fee Direct Grants**				$ -	$ -	$ -	$ -
5	**Other Payer Revenues**				$ -	$ -	$ -	$ -
6	**Revenues from County Funding**							
	Health Realignment Indigent Care							
	6a			1991 Health Realignment funds **received** from the State to the county:				
		i		Sales Tax Account and Sales Tax Growth Account	$ -	$ -	$ -	$ -
		ii		Vehicle License Fee Account and Vehicle License Fee Growth Account	$ -	$ -	$ -	$ -
	6b			1991 Health Realignment funds **used** for Indigent Health Services				
		i		Public hospital system	$ -	$ -	$ -	$ -
		ii		Public clinics	$ -	$ -	$ -	$ -
		iii		Other health service providers	$ -	$ -	$ -	$ -
	Imputed County Low-Income Health Amount (County Subsidy)							
	6c			County General Fund Contribution				
		i		Public hospital system	$ -	$ -	$ -	$ -
		ii		Public clinics	$ -	$ -	$ -	$ -
		iii		Other health service providers	$ -	$ -	$ -	$ -

AB 85 Public Hospital County Data Submission Form

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Data inputed required

Select County from List					**Select County from List**			
Items from companion guide				**REVENUE OR COST**	**FY 2008-09**	**FY 2009-10**	**FY 2010-11**	**FY 2011-12**
REVENUES			**Data Source**	***All revenues and costs unless otherwise noted Excludes Nursing Facilities, duals, mental health, and substance use disorder services) * All revenues should be net of any IGT or CPE (represents FFP only)**				
	Special Local Health Funds							
	6d			County Tobacco Settlement funds **available** from the Master Settlement Agreement	$ -	$ -	$ -	$ -
	6e			County Tobacco Settlement funds **used** for Bonds and Securitizations	$ -	$ -	$ -	$ -
	6f			Restricted Tobacco Settlement Funds **available (include MH & SU)**:				
		i		Public hospital system	$ -	$ -	$ -	$ -
		ii		Public clinics	$ -	$ -	$ -	$ -
		iii		Other health service providers	$ -	$ -	$ -	$ -
	6g			Restricted Tobacco Settlement Funds **available (exclude MH & SU)**:				
		i		Public hospital system	$ -	$ -	$ -	$ -
		ii		Public clinics	$ -	$ -	$ -	$ -
		iii		Other health service providers	$ -	$ -	$ -	$ -
	6h			Unrestricted Tobacco Settlement Funds **available (include MH, SU and funds available for purposes other than health)**:				
		i		Public hospital system	$ -	$ -	$ -	$ -
		ii		Public clinics	$ -	$ -	$ -	$ -
		iii		Other health service providers	$ -	$ -	$ -	$ -
	6i			Unrestricted Tobacco Settlement Funds **available** for health **(exclude MH & SU)**:				
		i		Public hospital system	$ -	$ -	$ -	$ -
		ii		Public clinics	$ -	$ -	$ -	$ -
		iii		Other health service providers	$ -	$ -	$ -	$ -
	6j			Restricted Assessments and Fees **available** to the County **(include MH & SU)**:				
		i		Public hospital system	$ -	$ -	$ -	$ -
		ii		Public clinics	$ -	$ -	$ -	$ -
		iii		Other health service providers	$ -	$ -	$ -	$ -
	6k			Restricted Assessments and Fees **available** to the County **(exclude MH & SU)**:				
		i		Public hospital system	$ -	$ -	$ -	$ -
		ii		Public clinics	$ -	$ -	$ -	$ -
		iii		Other health service providers	$ -	$ -	$ -	$ -
	6l			Unrestricted Assessments and Fees **available** to the County **(include MH, SU and funds available for purposes other than health)**:				
		i		Public hospital system	$ -	$ -	$ -	$ -
		ii		Public clinics	$ -	$ -	$ -	$ -
		iii		Other health service providers	$ -	$ -	$ -	$ -
	6m			Unrestricted Assessments and Fees for health services **available** to the County **(exclude MH & SU)**:				
		i		Public hospital system	$ -	$ -	$ -	$ -
		ii		Public clinics	$ -	$ -	$ -	$ -
		iii		Other health service providers	$ -	$ -	$ -	$ -
	6m			One-Time and Carry-Forward Revenues	$ -	$ -	$ -	$ -
7	**Medi-Cal Costs**							
	Medi-Cal FFS							
	7a		P-14	Inpatient FFS	$ -	$ -	$ -	$ -
	7b		P-14	Hospital Outpatient FFS	$ -	$ -	$ -	$ -
	7c		P-14	FQHC Medi-Cal Costs (non-managed-care members)	$ -	$ -	$ -	$ -
	7d			Non-Hospital Service Costs	$ -	$ -	$ -	$ -
	7e		P-14	Physician Costs	$ -	$ -	$ -	$ -
	7f			Intergovernmental Transfers to Fund Private Entitles	$ -	$ -	$ -	$ -
	Medi-Cal Managed Care							
	7g		P-14	Inpatient Costs	$ -	$ -	$ -	$ -
	7h		P-14	Hospital Outpatient Costs	$ -	$ -	$ -	$ -
	7i		Other	Outpatient Non-Hospital Costs	$ -	$ -	$ -	$ -
	7j		Other	Physician Costs	$ -	$ -	$ -	$ -
	7k		Other	FQHC Costs	$ -	$ -	$ -	$ -
	7l			Out-of-Network Costs	$ -	$ -	$ -	$ -
	7m			Allowable Administrative Costs	$ -	$ -	$ -	$ -
8	**Demonstration/Expansion Population Costs (CI/HCCI/MCE)**							
	8a		P-14	Coverage Initiative (CI) Costs	$ -	$ -	$ -	$ -
	8b		P-14	Health Care Coverage Initiative (HCCI) Costs	$ -	$ -	$ -	$ -
	8c		P-14	Medicaid Coverage Expansion (MCE) Costs	$ -	$ -	$ -	$ -

AB 85 Public Hospital County Data Submission Form

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Select County from List					**Select County from List**			
Items from companion guide				**REVENUE OR COST**	**FY 2008-09**	**FY 2009-10**	**FY 2010-11**	**FY 2011-12**
REVENUES			**Data Source**	***All revenues and costs unless otherwise noted Excludes Nursing Facilities, duals, mental health, and substance use disorder services) * All revenues should be net of any IGT or CPE (represents FFP only)**				
9	**Uninsured Costs**							
	9a			Inpatient Costs	$ -	$ -	$ -	$ -
	9b		P-14	Hospital Outpatient Costs	$ -	$ -	$ -	$ -
	9c		P-14	Outpatient Non-Hospital Costs	$ -	$ -	$ -	$ -
	9d		Other	Physician Costs	$ -	$ -	$ -	$ -
	9e			Maddy Fund Costs	$ -	$ -	$ -	$ -
10	**Other Costs**							
	10a			Total Health System Costs	$ -	$ -	$ -	$ -
	10b			Other Costs	$ -	$ -	$ -	$ -
	10c			Non-allowable / non-billable / non-reimbursable costs under Medi-Cal Cost Report	$ -	$ -	$ -	$ -
	10d			Other Payer Costs (10b minus 10c)	$ -	$ -	$ -	$ -

11	**Historical Amounts and Percentages**				
	a			Health Realignment Indigent Care Percentage	0.00%
	b			Imputed County Low-Income Health Percentage	#DIV/0!
	c			Imputed County Low-Income Health Amount	#DIV/0!
	d			Imputed Gains from other Payers	#DIV/0!
	e			Imputed Other Entity Intergovernmental Transfer Amount	$ -
	f			Special Local Health Funds	
		i		Restricted Tobacco Settlement Funds Percentage	#DIV/0!
		ii		Restricted Assessments & Fees Percentage	#DIV/0!
		iii		Unrestricted Tobacco Settlement Funds Percentage	#DIV/0!
		iv		Unrestricted Assessments & Fees Percentage	#DIV/0!