

**AB 85 – DPH Counties
Data Submission Guide
FY 2015-16 Projected Data**

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 develop the interim calculations for the FY 2015-16 county savings determination process pursuant to the Welfare and Institutions (W&I) Code Section 17612.3.

The data requested in this guide must be submitted to the DHCS by October 13, 2014.

“Base year” means the fiscal year (FY) ending three years prior to the fiscal year for which the interim redirected amount is calculated. For the FY 2015-16 interim redirection calculations, the base year is FY 2012-13 actuals.

“Projected year” means the fiscal year for which the interim redirection amount is calculated. For the FY 2015-16 interim redirection calculations, the projected year is FY 2015-16.

Data Submission

The county’s data submission must include the following components:

Signed County Certification Form

A signed hardcopy of the County Certification Form must be signed by an appropriate county official (Auditor/Controller, CAO, or the Health Agency Director) and be submitted to DHCS attesting to the accuracy of the data submitted. The County Certification Form can be found on the AB 85 website at the link below.

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

Indexed Binder

All data and supporting documentation must be clearly organized and must be indexed by the line item on the data submission form (i.e. Item 5d should include the amount of county tobacco settlement funds available from the Master Settlement Agreement). Each tab should include all the supporting documentation necessary for the Department

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to confirm the amounts reported. This includes general ledgers, spreadsheets, crosswalks, etc. Please see the supporting documentation section for more information.

Compact Disk

Due to the size of the data submissions, the Department is requesting that all data be submitted via US mail on a compact disc. Any calculations that were originally done in excel, must be saved on the compact disc in excel format, not PDF. DHCS will be checking the methodology used in the calculations. All files saved on the compact disc must be saved with a reference to the data submission form line. For example, a file that includes data for line item 6e would be named “6e - Physician Costs.xlsx”

Data Submission Form

I. “DPH Data Submission” tab

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

All data provided must be submitted with supporting documentation such as the applicable pages from the Comprehensive Annual Financial Report; P14; Agreements; Checks and Remittance Advices. All source documents and starting amounts must be clearly identified in the submission of the supporting documentation. Please provide an explanation for methodologies used, and show calculations in Excel. If ad-hoc reports are provided as supporting documents, provide and describe the source data. 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.

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Historical Amounts and Percentages

Below are the historical amounts and percentages from the final determination letters that were issued on January 31, 2014. If the county believes that the data provided is incorrect or inconsistent with the final determination letter, please contact DHCS.

Restricted Assessment & Fees Percentage
Unrestricted Assessment & Fees Percentage
Restricted Tobacco Settlement Funds Percentage
Unrestricted Tobacco Settlement Funds Percentage
Imputed Gains from Other Payers
Imputed County Low-Income Health Amount (County Subsidy)
Imputed County Low-Income Health Percentage
Historical Realignment Indigent Care Percentage
Imputed other entity IGT amount

1. MEDI-CAL REVENUES

Medi-Cal 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

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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 and 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 1b" should be deleted for this calculation.
2. Pick up the net Medi-Cal cost on the P14, Schedule 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.
3. Add back the administrative day payments, Schedule 3, Step 3, line labeled "Estimated Admin day payments for cost report year", column for FY12-13.
4. Add back “state-only” payments. This is the state-only percentage on Schedule 2.1, Step 1 multiplied by Medi-Cal FFS days on Schedule 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 allowance (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.

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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. Provide FQHC PPS Reconciliation worksheets.

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. Provide supporting documentation to show calculations.

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 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.

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The county may include total payments based on P14 costs (exclude psych and dual-eligible payments), which are on Schedule 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 project the FFP portion of the estimated payment received. The county may estimate payments based on the unreimbursed cost of Medi-Cal inpatient and outpatient services as calculated on P14 Schedule 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.

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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. Payments for hospital-based FQHCs should be excluded and reported in 1m.

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 therapies, ambulance, etc., but should exclude payments for FQHCs, which are reported in 1m. 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 Payments

Counties should report both base payments for FQHC services from health plans and wraparound payments from the state (the supplemental payments issued by DHCS for FQHC visits). Wraparound payments 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 the actual wraparound payments received (code 18 and 19) as well as the reconciliation amount due from DHCS. The wraparound 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.

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Other Supplemental Revenues

1o. Hospital Fee Managed Care Revenues

The hospital fee managed care component should be based on actual or estimated amounts for the FY. The amounts paid by the plans were per a predetermined allocation per FY.

1p. SB 1732 Revenues (Construction and Renovation Reimbursement Program)

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 for both traditional Medi-Cal and new Medi-Cal 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.

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 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. 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 DSH received for the projected year and anticipated reconciliations, less any amount attributed to excluded Medi-Cal and uninsured services (MH, SU and NF).

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2. Medicaid Demonstration Revenues

2a. 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.

2b. Medicaid Coverage Expansion (MCE) Revenues

MCE revenues are based on costs calculated on the P14, multiplied by the applicable FMAP. 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, Schedule 2.1-A, Steps 10 and 11. For FY 2012-13, if the county chooses a CPE-based reimbursement, the county may use the calculated FFP for actual costs from the P14, Schedule 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.

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

DSRIP revenues reported by the county should include the projected amount of DSRIP net payment for the projected year (gross payment less the IGT used to claim the payment). Do not include the nonfederal share IGT, report only the FFP. Provide DSRIP payment summary as backup.

2d. Safety Net Care Pool (SNCP) Revenues

The amount reported should account for the SNCP received for the projected year 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

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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 30-month hospital fee (QAF III) runs from July 1, 2011 through December 31, 2013. Direct grant payments were made for the FY 2012-13 period. Payments are based on the amount of the fee actually collected, and should represent the total amounts.

5. 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 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 (Chapter 358, Statutes of 2013). The 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

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.

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5a. 1991 Health Realignment funds received from the State to the County

Report the projected total amount of 1991 Health Realignment funds that will be allocated to the county for the projected year. Attached are the current projected amounts of the 1991 Health Realignment funds provided by the Department of Finance.

DHCS will use the most recent projected total amount of 1991 Health Realignment funds from the State once released by the Department of Finance. Health realignment funds include the amounts allocated to the county from the following accounts:

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

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

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 projected for the projected year. The amount of tobacco settlement funds and assessments and fees 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.

5b. County Tobacco Settlement funds available from the Master Settlement Agreement

For the projected year, verify the **projected amount** of tobacco settlement funds **available** to the county pursuant to the Master Settlement Agreement entered into on November 23, 1998 by the State and leading US tobacco product manufacturers. Attached are the current projected amounts of the tobacco settlement funds provided by the Department of Justice.

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5c. County Tobacco Settlement funds used for Bonds and Securitization

Of the total available county tobacco settlement funds determined in 5d above, provide the total **projected** amount **used** for bonds and securitization for the projected year.

5d. Restricted Tobacco Settlement Funds available to the County for Health Services (including MH/SU)

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

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

Please note that in the 08-09 through 11-12 historical data, no county reported any restricted tobacco settlement funds (they were all unrestricted in character).

5e. Restricted Tobacco Settlement Funds available to the County for Health Services (excluding MH/SU)

For the projected year, provide the **total amount** of tobacco settlement funds **available** to the county entities 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

Please note that in the 08-09 through 11-12 historical data, no county reported any restricted tobacco settlement funds (they were all unrestricted in character).

5f. Unrestricted Tobacco Settlement funds available to the County

For the projected year, 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

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5g. Unrestricted Tobacco Settlement funds available to the County for Health Services

For the projected year, 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

5h. Restricted Assessments and Fees available to the County for Health Services (including MH & SU)

For the projected year, provide the **total amount** of restricted assessments and fees **available** to the county entities 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

5i. Restricted Assessments and Fees available to the County for Health Services (excluding MH & SU)

For the projected year, provide the **total amount** of restricted assessments and fees **available** to the county entities 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

5j. Unrestricted Assessments and Fees available to the County

For the projected year, 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

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5k. Unrestricted Assessments and Fees available to the County for Health Services

For the projected year, 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

COSTS

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

6. Medi-Cal Costs

6a. Inpatient FFS Costs

The county will report total inpatient FFS costs from the P14 prior to any payment offsets. This may be determined from the P14, Schedule 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 Schedule 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. The county should include state only programs for those included in the Medi-Cal settlement data.

6b. 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.

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6c. 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.

6d. 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)).

6e. Physician Costs

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

6f. Intergovernmental Transfers to Fund Private Entities

The county can include IGT costs for the projected year 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.

6g. New Mandatory Other Entity IGT

For the projected year, report any other entity intergovernmental transfer amounts newly mandated by the state after July 1st, 2013, as defined by Section 17612.2(ad).

Medi-Cal Managed Care Costs

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6h. Inpatient Costs

The county can identify costs on the P14, Schedule 2.1, Step 2, Col. 4. The amount should be the gross cost before payment offsets. MH, SU and NF services will have to be excluded if included here.

6i. Hospital Outpatient Costs

The county can identify costs on the P14, Schedule 2.1, Step 2, Col. 4. 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 6l below).

6j: 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). Medi-Cal managed care visits can be obtained from PPS reconciliation worksheets.

6k. 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.

6l. FQHC Costs

The county can identify FQHC costs using the cost claiming methodology used in the P14, Schedule 1, 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.

6m. 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

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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.

6n. 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.

7. Demonstration/Expansion Population Costs (HCCI/MCE)

7a. Health Care Coverage Initiative (HCCI) Costs (including allowable admin)

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

7b. Medicaid Coverage Expansion (MCE) Costs (including allowable admin)

The county can identify MCE costs on the P14. MCE costs are calculated on P14 Schedule 1 for hospital-based services, Schedule 4 for non-hospital services, and Schedule 5 for non-hospital MH and SU services. These costs are summarized to some extent on the P14, Schedule 2.1-A, Steps 11A through 11E, but that summary excludes costs recorded as under capitation or as other county's programs. 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 Schedule 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.).

8. 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

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private providers for these services, the cost is the amount of the contractual payment for the uninsured (non-LIHP) only.

8a. Inpatient Costs

The county can identify these costs for services provided by the DPH on the P14. If the P14 includes MH services for the uninsured, this will need to be recalculated to exclude them.

8b. Hospital Outpatient Costs

Hospital outpatient costs for services provided by the county are identified on the P14. If the P14 includes MH services for the uninsured, this will need to be recalculated to exclude them.

8c. 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. For the FY, these costs are all entered on Schedule 4 and Schedule 5 (MH). These costs are summarized on Schedule 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.

8d. 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 Schedule 1B and summarized on P14 Schedule 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 Schedule 1B.

8e. Maddy Fund Costs

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

9. FY 2015-16 Redirection Amount

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This section shows the interim realignment redirection amount resulting from trending forward from the submitted data in this tab, calculated in the other tabs. It is provided for reference only.

II. “DPH Assumptions Input” tab

With the implementation of ACA, in January 2014 some program changes and shifts occur. In order to accurately account for the program changes for the projected year, DHCS in collaboration with CAPH has developed an assumption model (“Assumptions and Adjustments” tab). The “DPH Assumptions Input” tab shows DHCS’ assumptions for the program shifts. If you are in disagreement with the assumptions provided, you may change the assumptions. Justification shall be provided for changes made in the assumptions. The assumptions worksheet is divided into four sections – Eligibility, Take-Up, Retention, and Reimbursement of Cost.

The FY 2012-13 data will be trended to FY 2015-16 using trend factor provided by each county.

In the “Eligibility” section, the assumptions predict how and what percentage of the population (or costs in this case) in the base year will transition to new program(s) in the projected year. For example, LIHP-MCE will be fully transitioned to Medi-Cal; therefore, the model assumes that 100% of MCE IP and MCE OP to be eligible for Medi-Cal. Similarly, it assumes that 100% of HCCI will be eligible to transition to Covered CA.

The “Take-Up” section assumes the percentage of eligibles (above) that will be taken up by and enrolled in the new programs/systems listed in the chart below. These assumptions reflect a percentage of a percentage. For example, out of 100% MCE MC IP eligibles, only 95% of them are assumed to be taken-up or enrolled in the program.

The “Retention” section projects the percentage of the “Take-up” population (costs) that will actually be retained and continue receiving services.

The “Reimbursement of Cost” section reflects estimated reimbursement rates that will be used to project revenues for the new costs after Health Care Reform.

The abbreviations used in the model are listed below.

MCE MC IP	MCE Medi-Cal Inpatient
MCE MC OP	MCE Medi-Cal Outpatient
HCCI CovCA IP	HCCI Covered CA Inpatient
HCCI CovCA OP	HCCI Covered CA Outpatient
UN MC Full IP	Uninsured Medi-Cal Full Inpatient

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UN MC Full OP	Uninsured Medi-Cal Full Outpatient
UN CovCa IP	Uninsured Covered CA Inpatient
UN CovCa OP	Uninsured Covered CA Outpatient
UN MC LS IP	Uninsured Medi-Cal Limited Scope Inpatient
UN MC LS OP	Uninsured Medi-Cal Limited Scope Outpatient
UN MC PE IP	Uninsured Medi-Cal Presumptive Eligibility Inpatient
UN MC PE OP	Uninsured Medi-Cal Presumptive Eligibility Outpatient

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 tobacco data published on the DOJ's webpage would be considered source data as it contains the original amounts provided by the State to the county.

Narrative

A detailed narrative shall be submitted. The narrative must guide the reviewer through the documents provided and each calculation performed. An explanation of why the calculation was needed and assumptions should also be included in the narrative.

Supporting Calculations

Supporting calculations should contain formulas or steps that were performed in any allocation methodology. This allows the reviewer to follow each step that was performed, from the original source data amount to the final amount that is reported on the data submission form. All supporting calculation shall be included in the binder and provided as a soft copy in excel format.

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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)