



TOBY DOUGLAS  
DIRECTOR

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



EDMUND G. BROWN JR.  
GOVERNOR

March 4, 2014

PPL: 13-011

To: LOS ANGELES COUNTY ADMINISTRATIVE OFFICERS  
LOS ANGELES COUNTY HEALTH EXECUTIVES

**SUBJECT: AB 85 Final Resolution Form – Los Angeles County**

### **Purpose**

The purpose of this policy and procedure letter is to provide guidance to Los Angeles County regarding the submission of the Final Resolution form to meet the provisions specified in Assembly Bill (AB) 85 (Chapter 24, Statutes of 2013).

### **Background**

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

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

Los Angeles County submitted their tentative decision by November 1, 2013 in accordance with Section 17600.50(c) of the Welfare and Institutions (W&I) Code.

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

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## **Final Resolution Form**

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

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

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

Please complete and return the form to:

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

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

Thank you,

## **Original Signed by Pilar Williams**

Pilar Williams  
Deputy Director, Health Care Financing

Enclosures:

- Final Resolution Form

cc's: On next page

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cc: Diane Cummins  
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**Final Resolution for Determining Payments to the Family Support Subaccount**

In compliance with Section 17600.50(c) of the Welfare and Institutions code, Public Hospital Health System Counties (which include, Alameda, Contra Costa, Kern, Los Angeles, Monterey, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, and Ventura) must adopt a resolution by January 22, 2014 informing the Department of Health Care Services of the County’s final decision to choose either the County Savings Determination Process or the 60/40 formula option.

\_\_\_\_\_ County chooses the option selected below  
County Name

to determine payments to the Family Support Subaccount:

**County Savings Determination Process** - The formula pursuant to Welfare and Institutions (W&I) Code, Section 17612.1. The county acknowledges that upon choosing this option, this determination method is final and not subject to change.

**OR**

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

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

\_\_\_\_\_ Date \_\_\_\_\_  
County Official (Signature)

\_\_\_\_\_  
County Official Title