Interim Hospital Payment Rate Workbook Instructions

This Interim Hospital Payment Rate Workbook (Workbook) provides a simplified way to obtain the costs associated with the various categories of reimbursement under the 1115 Medi-Cal Hospital / Uninsured Care Demonstration (Demonstration) (Waiver 11-W-00193/9, the Physician SPA (05-023), and the LA County CBRC SPA). This Workbook is designed for FY ’10-’11 and incorporates part of DY5 (7/1/10 - 8/31/10), the extension period from the 2005 waiver (9/1/10 - 10/31/10), and DY6, an eight-month period under the 2010 waiver (11/1/10 - 6/30/11).

Changes in FY11 Workbook

There are some significant changes between this workbook and previous workbooks:

1. All categories of settlement data have separate columns for Inpatient and Outpatient services.
2. Schedules 2 Projected and 2-A Projected, and 2.1 Fiscal Year and 2.1-A Fiscal Year have been redesigned to accommodate the new waiver categories. Schedules 2 and 2A are significantly different from 2.1 and 2.1-A since there is a single FMAP in the projection year. Schedule 2-A1 LIHP Projections has been added to allow detailed HCCI and MCE projections and a comparison of costs per enrollee to the HCCI and MCE Cap Rates.
3. Fields have been added in Schedule 3 to collect discharge data.
4. Schedule 3.1 has been added to obtain detailed payment data that is used to offset costs. Please note that Medi-Cal payments for inpatient and outpatient hospital services that exceed the costs of those services, "profit from Medi-Cal", for Psych, Medi-Cal Managed Care, Out of State Medicaid, Medicaid Coverage Expansion (MCE) from another county, and MCE based on actuarially sound capitation rates must be used to reduce Uncompensated Care Costs (UCC) for DSH purposes. HCCI capitation payments for hospital services that exceed the cost of those services must also be used to reduce UCC costs for DSH purposes.
5. Tabs have been added to accommodate the three FMAPs applicable to the fiscal year.
6. Columns have been added as necessary to accommodate audit needs and to assure all costs and payments are accounted for.
7. Schedules 4 and 5 have been expanded to include HCCI and MCE program costs.
8. Inpatient hospital services provided to certain prisoners are reimbursable under the MCE program. Columns have been added to Schedule 1 to identify these costs at the county’s hospital. Fields have been added to Schedules 2-A and 2.1-A to include State payments made for hospital inpatient services to other hospitals on behalf of prisoners enrolled in the county's MCE program. These costs can be included based on the State's certification of the expenditure.
9. Columns have been added to identify Out-of-State Medicaid costs. Any shortfall is considered UCC for DSH purposes.
General Requirements

The Coverage Initiative (CI) was funded through the 2005 waiver for the eight “legacy” member counties under a capped amount, and was extended to 10/31/10. For the period 7/1/10 - 8/31/10, the funding for the CI comes from the DY 5 allotment of $180 million. For the extension period 9/1/10 - 10/31/10, CI funding comes from the DY6 allotment. Beginning 11/1/10 the CI was replaced by the Low-Income Health Program (LIHP) under the successor 2010-2015 “Bridge to Reform” waiver. In FY 10-11, all legacy counties with existing CI programs transitioned to the LIHP effective 11/1/10. The LIHP is comprised of two components. The Medicaid Coverage Expansion (MCE) component allows for coverage of enrolled individuals up to 133% of the Federal Poverty Limit (FPL). This program is not subject to budget neutrality and costs and reimbursement are treated in a manner similar to the Medi-Cal program. Each LIHP county sets the upper FPL for eligibility under its MCE program. If a legacy county sets eligibility for its MCE below 133% of FPL, existing CI enrollees between the new threshold and 133% of the FPL are considered MCE enrollees for reimbursement purposes. The Health Care Coverage Initiative component (HCCI) covers individuals between 133% and up to 200% of the FPL. Like the CI, HCCI funding is a capped amount. HCCI funding from 11/1/10 - 6/30/11 is funded from the DY6 allotment, from which CI funding for the two-month extension also is funded. Since the funding is administered using these fiscal periods, there are columns in the schedules marked “July-Dec” that require reporting CI settlement data for the two periods 7/1- 8/30 and 9/1-10/31. For the period 11/1-12/31, there are columns for both MCE and HCCI settlement data. This will allow reconciliation with the annual award amounts based on the CI fiscal year.

Designated Public Hospitals can elect payments for both the HCCI and MCE components based either on Certified Public Expenditures (CPEs) - Attachment G, Supplement 1 or on actuarially sound capitation rates – Attachment G, Supplement 2. This election can be made separately for Medical Services and for Mental Health Services. Capitation rate based payments for DSH eligible hospital inpatient and outpatient services (exclusive of professional service components) that exceed the cost of those services must be used to reduce the UCC costs for DSH purposes. The selection is identified on Schedule 1 (July–Dec) in the appropriate columns. To the extent certain services are not included in the calculation of the capitation rates, the cost of those services will be reimbursed as CPEs (Costs Always CPE Based). NOTE: No LIHP’s were capitated in FY11. The selection on schedule 1 applies to FY 12.

For each set of instructions below, the settlement data must be entered for the appropriate fiscal period.

Los Angeles County may substitute RVU’s for charges.

NOTE: For Fiscal Year ’10-'11 there are three FMAP rates: 61.59% for the period 7/1/10 - 12/31/10; 58.77% for the period 1/1/11 - 3/31/11; and 56.88% from 4/1/11 - 6/30/11. (The increased FMAP rate does not apply to the DSH calculation. The DSH FMAP remains at 50%.) This workbook contains three copies of Schedules 1.1, 1, 1A, 1B, and 1B-UC, one for each FMAP period. Each schedule is marked for the effective months.
For the purpose of submission, unless otherwise indicated, the provider will use the applicable "as filed and accepted" Medi-Cal Cost Report filed with A&I. Data and information from other than the "as filed and accepted" Medi-Cal Cost Report, or data outside of the "as filed and accepted" Medi-Cal Cost Report, must be accompanied by sufficient supporting documentation. This set of worksheets requires the following input:

1. Two sets of per diems and cost-to-charge ratios:
   a. traditional Medi-Cal without physician and non-physician practitioner professional costs;
   b. traditional Medi-Cal without physician and non-physician practitioner professional costs, but with the additional costs allowable under Attachment D.

2. Physician professional component costs from Worksheet A-8-2 and non-physician practitioner professional component costs, certain costs related to physician professional activity from Worksheet A-8 for county hospitals, or for University of California entities from a separate cost report which includes the applicable University indirect cost rate for UC entities, and total physician and non-physician practitioner billed professional charges. These costs and charges must be entered for each fiscal period.

3. The following categories of settlement data entered once for each fiscal period:
   a. IP Medi-Cal FFS days and charges, including Administrative days and charges, Medicare/Medi-Cal crossover days and charges for full dual eligible QMB+ and SLMB+ (Medi-Medi) for which Medi-Cal payment is made, and charges related to services that previously were carved-out from the CMAC rate (carve-out services);
   b. IP and OP Medi-Cal Managed Care days, visits and charges;
   c. IP and OP Medi-Cal Psychiatric days, visits and charges;
   d. IP and OP Out-of-state Medicaid days, visits and charges (including Medi-Medi);
   e. IP and OP days, visits and charges for LIHP patients enrolled in another county’s MCE program (not including MCE enrolled prisoners).
   f. IP and OP Uninsured days, visits and charges;
   g. IP and OP days, visits and charges related to the Coverage Initiative (CI);
   h. IP and OP days, visits and charges related to the HCCI Program Medical Services;
   i. IP and OP days, visits and charges related to the HCCI Program Mental Health Services;
   j. IP and OP days, visits and charges related to the HCCI Program Substance Abuse Services, services covered by Ryan White and/or Aids Drug Assistance Program (ADAP) funding, and physical health services not considered in the capitation rate;
   k. IP and OP days, visits and charges related to the MCE program Medical Services;
   l. IP and OP days, visits and charges related to the MCE program Mental Health Services;
   m. IP and OP days, visits and charges related to the MCE Program Substance Abuse Services, services covered by Ryan White and/or Aids Drug Assistance Program (ADAP) funding, and physical health services not considered in the capitation rate;
   n. IP days and charges related to specific MCE enrollees of the county LIHP who are only eligible while admitted as an inpatient (State Prisoners). Projected costs can be entered on Schedule 2A-1.
Schedule

The following categories of payment received, entered once for each fiscal period must be reported on the new Schedule 3.1:

a. Medi-Cal revenue paid outside the Demonstration to offset costs included in the Demonstration; (e.g. Payments for Administrative Days and Carve Out Services.)

b. Medicare and Medi-Cal payments received for full dual-eligible (Medi-Medi) beneficiaries, and any patient payments of Medi-Cal Share of Cost obligations if applicable;

c. Medi-Cal Managed Care and Medi-Cal Psychiatric revenue, excluding that portion of payments paid for physician professional services and non-hospital services. Medi-Cal Managed Care payments include IGT-funded payments reported as the gross payment amount received from the Managed Care Plan(s), reduced by any portion applicable to physicians or non-hospital services. Medi-Cal Managed Care payments also include the gross amounts of non-grant hospital fee payments received from the Managed Care Plan(s). If payments are made under the hospital fee program for psychiatric days, payments will need to be reported for offset against the Psych shortfall.

d. Out-of-state Medicaid payments;

e. Payments received from another county for their MCE enrollees and payments made by and on behalf of these patients.

f. Payments received from the California Department of Corrections for another county’s MCE enrollees.

g. Payments made by and on behalf of individual uninsured patients, including payments made for Attachment D, Physician Professional Services, and non-hospital services;

h. SB1732 payments (note that separate amounts are entered on Schedule 3.1 for each fiscal period reflecting different payments in the reported fiscal year and the projected project year);

i. Section 1011 payments, excluding any portion related to a physician professional component;

j. Section 330 Grants received by FQHCs, unless the costs funded by such grants have been removed prior to cost finding;
k. Payments made by or on behalf of patients enrolled in the HCCI or MCE programs;
l. Payments from the State or County Department of Corrections for inpatient services provided to MCE enrollees;
m. Capitated rate based payments from the LIHP for rate based programs;
n. Medi-Cal payments for physician professional services and payments made by or on behalf of Medi-Cal patients for physician professional services;
o. Payments made by or on behalf of patients receiving CBRC services; and
p. Medicare allowable amounts for IP and OP physician professional services provided to full dual eligibles.
q. For Alameda County, payments received from the LIHP for HCCI hospital inpatient and outpatient services, and the Alameda County HCCI allotment for Medical, Mental Health and CPE reimbursed services.

5. Trending factors for FY 2012 that require adjustments to interim costs that are not accounted for in the chosen CPI index. These include costs in the fiscal year that are not expected to be included in the projected fiscal year and costs anticipated in the projected fiscal year that are not included in the fiscal year data.

6. Costs of hospital services for each fiscal period that apply only to the uninsured, e.g., contracts with other hospitals for indigent care services that are the responsibility of the hospital.

7. Costs of non-hospital services for each fiscal period to the uninsured that are claimable from the SNCP, e.g., non-hospital clinics, mental health services, and payments to private entities, including Coverage Initiative services and LA County costs for Medi-Cal services reimbursed under the CBRC SPA. LA County must report the excess CPEs it used to draw down the South LA fund for the period 7/1/10 - 10/31/10.

8. As established with CMS, the designated public hospitals are not required to conduct medical necessity reviews with respect to services to the uninsured whose costs form the basis of the DSH and SNCP claims, or to apply a medical necessity adjustment to the total uncompensated costs that form the basis of the DSH and SNCP claims. Therefore, no specific medical necessity adjustment is necessary.

NOTE: Because much of the data in the Workbook is based on the hospital’s as filed and accepted Medi-Cal cost report, if a designated public hospital submits an amended cost report to Audits & Investigations with amended data, the hospital must inform the Safety Net Financing Division (SNFD) staff and submit to SNFD a copy of the amended cost report, a revised copy of the Workbook that includes amended cost information, and sufficient supporting documentation.

Please ensure that the data reported pertains to the specific fiscal year and fiscal period Workbook data request.

Identifying Information: Enter the Facility Name, Cost Report Fiscal Year, Workbook Filing Date, and Workbook Filename on the Instructions Tab (lines 2-5 purple). The Workbook filing date is the date of a formal request from DHCS. Please enter the official date and add "amended mm/dd/yy" for a refiled version. This information will flow to other schedules on the Workbook (blue).
If a hospital needs to insert lines to agree with the lines on the cost report, please be sure to insert the lines on all Schedules 1 (1.1, 1.2, 1.3, 1, 1A, and 1B). If a University Hospital needs to insert lines on Schedule 1B-UC, please be sure to insert the lines on Schedule 1.4 as well. Be sure to copy down all formulas when lines are inserted.

**Schedules 1.1**

Schedules 1.1 are the input schedules for Medi-Cal settlement data that will be used in Column 2a of Schedules 1. The Medicare/Medi-Cal crossover column (Medi-Medi) is for Medicare beneficiaries who have full Medi-Cal coverage for the services, e.g., QMB+ and SLMB+ beneficiaries. Enter Medi-Cal days and charges for Administrative and carve-out services in the appropriate columns.

The Medi-Medi days and charges may include days and charges not billed to Medi-Cal (and therefore not on the Medi-Cal paid claims report) in cases where the services do not have a co-pay obligation (deductible and coinsurance). Since the Medicare DRG payment system is designed to allow retention of payments in excess of cost, Medi-Medi days and charges for which Medi-Cal has no payment obligation (because Medicare program payments were in excess of cost) can be excluded. (NOTE: Be sure to exclude from the Medi-Medi data all days and charges that were billed to Medi-Cal when Medicare benefits were exhausted during an inpatient stay. Those days will be in the Medi-Cal paid claims data.)

Enter the Medi-Cal charges for inpatient unit services on the lines at the bottom of Schedules 1.1. These charges are not used in calculating costs; but they are used for other program purposes.

*Note that all charges must exclude the physician professional component. This includes charges for hospital based FQHC entities.*

**Schedules 1.2, 1.3, and 1.4**

These schedules provide annual, four month or eight month data for each payer category. These data are the sum of the data on the multiple schedules 1, 1A, 1B, and 1B-UC. They are provided for information purposes.

**Schedules 1**

Schedules 1 calculate the Medi-Cal costs for determining and establishing the Medi-Cal inpatient interim rate. The actual interim rate will be calculated on Schedule 2. Schedules 1 also calculate the Medi-Cal Managed Care, Medi-Cal Psychiatric, Out-of-State Medicaid costs (including costs of dual eligibles, and costs of another County’s MCE enrollees (excluding prisoners). These costs are used in determining the shortfalls that are considered Uncompensated Care Costs (UCC) claimable under DSH. Schedules 1 also calculate the Uninsured Hospital Costs that are claimable under DSH and/or SNCP. The basis of the cost-to-charge ratios must be the "as filed and accepted" Medi-Cal Cost report, and any changes/variances must be fully supported and documented and reconciled to the "as filed and accepted" cost report. Hospital-filed cost reports may need to be adjusted for this schedule to exclude physician professional fee cost and to show dental costs as allowable costs. W&I Code §14166.5 (c) requires that the cost...
finding methodology approved under the Demonstration be applied, and that the accounting and reporting practices be consistent with those applied in prior/subsequent years for those years covered under the Demonstration. All revisions and changes made to costs and charges that impact the cost-to-charge ratio must be summarized, described, and supported by sufficient documentation. Cost Center Descriptions should be revised as needed.

Enter the per diems and cost to charge ratios from the Medi-Cal cost report. **Note that the costs and charges used to calculate the per diems and cost to charge ratios and the program charges used to calculate costs must exclude the physician professional component. The physician professional component costs and charges in hospital based FQHC entities are also excluded. Physician professional component costs are determined on schedules 1B and 1B-UC of the workbook.**

Since the Medi-Cal auditors combine the psychiatric sub-provider with the adults and pediatrics cost center when computing the Medi-Cal per-diem, it is necessary to reconcile the separate per-diems used to calculate Medi-Cal and Medi-Cal Psych costs. On line 132 at the bottom of Schedule 1(Jul-Dec) please enter the total costs, total charges, and per-diems from the audited cost report; and on lines 134 and 135 enter the total costs and total charges for the adults and pediatrics and sub-provider cost centers. The table is designed to demonstrate the reconciliation.

In the appropriate column, by fiscal period, enter the patient days and patient charges for each cost center for Medi-Cal Managed Care, Medi-Cal Psychiatric, Out-of-State Medicaid, another County’s LIPH, and Uninsured. Enter total outpatient visits on worksheet Line B. Enter the charges for inpatient unit services on the lines at the bottom of Schedules 1. For the uninsured, enter the total IP and OP charges for services provided in the long term care cost centers (lines 26, 27, and 28). These charges are not used in calculating costs; but they are used for other program purposes.

Schedules 1 also include the calculations that are used for the hospital costs of the 2005 Waiver Coverage Initiative (CI), the 2010-2015 Waiver Health Care Coverage Initiative (HCCI) and the 2010-2015 Waiver Medicaid Coverage Expansion (MCE) program for the appropriate fiscal period. After 11/1/10, report days and charges for individuals enrolled in the county’s MCE program in the MCE column. Include the days and charges for individuals who had been previously enrolled in the CI program and whose incomes are between the FPL limit for the MCE program and 133% of the FPL. Days and charges for enrolled individuals between 133% and 200% of the FPL are reported in the HCCI column. (**NOTE: if the HCCI or MCE medical or mental health programs are capitation rate based in FY 12, please enter a 1 on Schedule 1 (July-Dec) columns 8d and/or 8h and/or 9d and/or 9h. If a program is rate based, the hospital cost shortfall or payments in excess of costs are included in the UCC costs for the DSH only CPE calculation.**) Enter the IP days and IP and OP charges for HCCI and MCE substance abuse services, services to enrollees who would otherwise be eligible for Ryan White and ADAP funding, and physical medicine services (not included in the capitation rate calculations). These costs are always reimbursed based on CPEs. Enter the inpatient days and charges for state prisoners and county jail inmates who are enrolled in the county’s MCE program. Also enter the inpatient days and charges for state prisoners enrolled in another county’s MCE program since those costs are included in the DSH only CPE calculation. Projected costs for CPE based programs and prisoners may be entered in Schedule 2A-1.
Enter total inpatient days and outpatient visits on line B for each payment category. Enter the charges for inpatient unit services on the lines at the bottom of Schedules 1. These charges are not used in calculating costs; but they are used for other program purposes.

The AB 915 costs can include full dual eligibles (QMB+ and SLMB+), and for LA County the calculations for Medi-Cal costs reimbursed under the CBRC SPA, are included on these schedules. Enter the total outpatient visits on Line B.

**Schedules 1A**

Schedules 1A calculate additional allowable SNCP costs under Attachment D of the Special Terms and Conditions for all hospitals. These schedules do not include physician and non-physician practitioner professional costs. To arrive at these costs, the trial balance on the cost report must be adjusted to include the Attachment D costs as allowable costs in the appropriate cost centers. Enter the revised per diems and cost to charge ratios from the rerun Medi-Cal cost report. The allowable SNCP costs are determined by subtracting the total costs from Schedules 1 (Line B) from the total costs on Schedules 1A (Line A). The difference (Line C) flows through to Schedules 2, 2-A, 2.1, and 2.1-A.

Schedules 1A also calculate allowable Attachment D uninsured costs related to the each category of the Coverage Initiative (CI), and Health Care Coverage Initiative (HCCI programs).

**Schedules 1B**

Schedules 1B calculate the allowable Medi-Cal FFS physician and non-physician practitioner costs that are included for reimbursement or supplemental reimbursement under SPA 05-023, the Physician SPA, and the uninsured physician and non-physician practitioner costs eligible for claiming from the SNCP. Physician and non-physician practitioner professional component costs are identified using time studies. For all non-physician practitioner costs, and for those hospitals that did not have approved Medicare time studies for any fiscal year under the waiver, the results of the time studies will be used to backcast costs to prior periods.

In Part I: Enter the physician professional component costs from Worksheet A-8-2, Column 4, in column 1. Enter any physician professional component costs that were eliminated on Worksheet A-8 in column 2. (Allocate these costs to the appropriate cost center if necessary.) Enter related business office, data processing, and administrative support costs that were eliminated on Worksheet A-8 as related to physician professional services in column 3. (Allocate these costs to the appropriate cost center as necessary.) Enter total billed professional charges in column 5. Enter the applicable Medi-Cal professional billed charges in the appropriate columns for each payment category (mutually exclusive). For the period 7/1/10 through 10/31/10, the inpatient costs count toward the hospital-specific baseline. Enter the Medi-Medi crossover IP and OP professional billed charges in the appropriate columns. Dual eligible Medi-Medi claims with Medi-Cal Managed care are not covered under the Physician SPA and
should be excluded. **Total reimbursement for Medi-Medi physician costs cannot exceed Medicare allowable amounts.** An adjustment to limit cost to the allowable amount is made on Schedule 3.1; please note that you will need to track the Medicare allowable amount for each claim. Use audited data, as applicable. Enter the Medi-Cal FFS OP charges that are eligible for reimbursement under the Physician SPA and the CBRC OP charges eligible under the CBRC SPA.

Enter the applicable Uninsured, Coverage Initiative (CI), Health Care Coverage Initiative (HCCI), and Medicaid Coverage Expansion (MCE) professional billed charges in the appropriate columns for each payment category (mutually exclusive).

**NOTE:** Because the FQHC PPS Rate is all-inclusive, Medi-Cal FQHC services are not eligible for reimbursement under the Physician SPA and should not be included.

In Part II: Enter the non-physician practitioner professional component costs that were eliminated on Worksheet A-8 by practitioner type in column 2. Enter related business office, data processing, and administrative support costs that were eliminated on Worksheet A-8 as related to the professional component of non-physician practitioners in column 3. Enter total billed professional charges by practitioner type in column 5. Enter the applicable Medi-Cal non-physician practitioner billed charges in the appropriate columns for each payment category (mutually exclusive). Enter applicable Uninsured, Coverage Initiative (CI), Health Care Coverage Initiative (HCCI), and Medicaid Coverage Expansion (MCE) professional billed charges as applicable in the appropriate columns (mutually exclusive). The resulting costs will be carried to Schedules 2-A and 2.1-A. **Please note that the same dual eligible Medi-Medi limitations as in Part I apply here.**

**Schedules 1B-UC**

Schedules 1B-UC calculate physician and non-physician practitioner professional fee costs for University costs that are not reflected on the hospital cost reports. Schedules 1B-UC allocate the professional fees to Medi-Cal inpatients and outpatients, Medi-Medi crossover inpatients and outpatients, and uninsured inpatients and outpatients. **Total reimbursement for Medi-Medi physician costs cannot exceed Medicare allowable amounts.** The Medi-Cal and Medi-Medi physician and non-physician practitioner professional fee costs are claimable under the Physician SPA. For the period 7/1/10 through 10/31/10, the inpatient costs count toward the hospital-specific baseline. Uninsured physician and non-physician practitioner professional fee costs are eligible for claiming under the SNCP. UC physician and non-physician practitioner professional component costs are calculated using the RVU methodology approved by CMS. For subsequent fiscal years, UC physician and non-physician practitioner professional component costs will be based on time studies. For the FY 10-11 initial submission, UCs should continue to use the RVU method since no time studies have been completed. Information provided must be supported by RVU documentation. Time studies have been started and costs will be adjusted by backcasting the results of those time studies at for fiscal years ’09-’10 and ‘10-’11 at reconciliation.
Non-capital supplies and equipment will be allowable as direct costs; indirect costs will be calculated by applying the applicable cognizant agency's indirect cost rate to the total direct costs. The costs will be apportioned based on billed professional charges.

Enter the physician professional component costs in column 1 and the related non-capital supplies and equipment in column 2. Enter the cognizant agency's indirect cost rate as a percentage in Column 1, Line 78. Enter the billed program charges in the appropriate columns.

**Schedules 2 Projected, 2-A Projected and 2-A1 LIHP Projected**

Schedules 2 Projected, 2-A Projected and 2-A1 Projected are used to calculate the interim rate for the year after the cost report year and to provide the cost data used to estimate Physician SPA, DSH, SNCP and MCE payments for the projected year. The costs from the cost report year are trended using the proposed Hospital & Related Services US City Average CPI Hospital index. That index is reported on Schedule 3 and used for projected costs. A hospital can adjust the CPI index downward by entering a lower projected CPI percentage. Volume adjustments are made either through projected days and visits applied to a cost per day or cost per visit, or by using a percentage increase or reduction. Cost per day or cost per visit adjustments are handled through Schedule 3. The total costs needed to claim the HCCI allotment (allotment divided by FMAP) are input in Schedule 2A.

**Schedule 2 Projected**

Schedule 2 Projected is used to calculate the various categories of expected hospital costs net of payments received for the projected fiscal year.

Step 1: The Medi-Cal interim rate for the projected fiscal year is identified in Step 1. Enter the total projected Medi-Cal days (excluding well baby, administrative and medi-medi days) on line 17. State Only Medi-Cal and the unreimbursed patient share of costs (uninsured costs) are identified as SNCP/DSH CPEs. Since the FMAP rate for FY 11-12 will be 50%, the data from the four FY 10-11 fiscal periods are combined to calculate the new rate.

Step 2: Medi-Cal Managed Care, Medi-Cal Psychiatric, Out-of-State Medicaid, another county’s MCE, and rate based MCE shortfalls are calculated in Step 2. These shortfalls do not include physician costs or revenues and are DSH-only eligible costs. *Note that where payments for these hospital services exceed the costs of the services DSH-only costs are reduced.* Enter the estimated program days for the projected year on line 34, columns 2-5. If the LIHP elects capitation payments for the MCE program, the data to calculate the shortfall (or payment in excess of cost) is brought forward from Schedules 2-A1 and 3.1.

Step 3: Inpatient and outpatient uninsured hospital costs are calculated in Step 3. These costs are eligible for DSH claiming and 86.05% of these hospital uninsured costs can also be eligible for SNCP claiming. Enter the estimated uninsured days for the projected year on line 48 and the estimated uninsured outpatient visits on line 51. Enter the estimated cost of drugs and supplies provided by the hospital to the uninsured on line 53. The total trended uninsured costs, reduced by the hospital's SB1732 payments, patient payments, and adjusted down by 13.95% for estimated services provided to
the undocumented, are DSH/SNCP costs. The costs applicable to the undocumented reduced by Section 1011 hospital payments are DSH-only costs. Enter the costs of drugs and supplies provided to uninsured patients on line 54.

Step 4: SNCP-only uninsured costs allowable through Attachment D are calculated in step 4. The annual Attachment D and physician professional component costs are brought forward from Schedule 2.1. Enter a positive or negative percentage volume adjustment on line 75 if applicable. Enter the direct costs of hospital services provided to the uninsured on lines 79-87. These costs include payments for physician services where the payments are specifically identified as payments for services to the uninsured; the costs of drugs provided to the uninsured outside the hospital setting; the cost of securing free drugs for the uninsured; and the costs of hospital services for the uninsured that are purchased from another hospital. If there are additional costs for services provided directly to the uninsured, provide a description and include the costs on Line 84 and the following lines. The total trended uninsured costs, reduced by patient payments and adjusted down by 13.95% for services provided to the undocumented, are SNCP eligible costs.

Step 5 summarizes the DSH-only, DSH/SNCP and SNCP-only hospital costs that are used in the distribution model.

NOTE: When re-filing a P14 after the projected year has been completed, where data is input into the schedule, please enter actual data.

Schedule 2-A Projected

Schedule 2-A Projected is used to calculate anticipated hospital and non-hospital costs, net of payments received, that are eligible for SNCP claiming for the projected fiscal year.

Step 6 is for calculating the non-hospital SNCP CPEs. Costs and payments are brought from Schedules 4 and 3.1. Enter on line 15 a positive or negative percentage volume adjustment that would affect the projected non-hospital costs. Adjustments to cost are handled on Schedule 3 and included as a trend factor. The volume adjusted trended costs, reduced by 13.95% for services to the undocumented and eligible SNCP only costs.

Step 7 is used to calculate uninsured costs related to the Health Care Coverage Initiative (HCCI) by type of program.

Step 7A is used to summarize projected costs for medical services. The HCCI costs are taken from the projected costs in Schedule 2-A1. Patient payments related to HCCI costs are taken from Schedule 3.1. If the LIHP elected capitation payments for these medical HCCI services in FY12, the capitation payment is compared to the costs of the services. If the capitation payment exceeds the cost of the services, the lesser of the amount the payments exceed costs, or the DSH eligible costs are used to reduce the uncompensated care costs for DSH purposes. The total capitation payment cannot exceed the HCCI allotment (see Attachment G – Supplement 2). If the LIHP elects CPE based reimbursement, enter the
total HCCI expenditures needed to claim the HCCI allotment for these services on line 38. This is the federal allotment divided by the 50% FMAP. **NOTE:** The hospital will have to allocate the allotment between medical, mental health, and other costs that are always CPE based and provide supporting documentation of the allocation. Costs in excess of the capitation payment or the allotment are included as eligible DSH/SNCP costs or SNCP-only costs. The HCCI allotment is allocated to SNCP-only costs before DSH/SNCP costs. **Designated Public Hospitals that have a contractual relationship with the County LIHP that is a separate entity from that which operates the DPH (e.g. Alameda) will report the amount received from the county for hospital medical services. This amount will be reported on Schedule 3.1.**

Step 7B is used to summarize projected costs for HCCI mental health services. Reimbursement for mental health services can be either capitation based or CPE based. Costs and payments are treated in the same way as costs and payments for HCCI medical services described in step 7A.

Step 7C calculates those costs that will always be based on Certified Public Expenditures (CPEs). These costs are costs excluded from the calculation of capitation payments and include substance abuse costs, services to HCCI enrollees who would otherwise be eligible for Ryan White and/or Aids Drug Assistance Program (ADAP) funding, and physical health services not considered in the determination of the capitation rate. This separation will be necessary if the hospital decides to go forward with capitation rates in the future and will want interim payments for CPE based services. The costs are brought forward from Schedule 2A-1 LIHP Projected and patient payments are brought forward from Schedule 3.1. Enter the total HCCI expenditures needed to claim the HCCI allotment for these services on line 38. This is the federal allotment divided by the 50% FMAP. The HCCI allotment is allocated to SNCP-only costs before DSH/SNCP costs.

**NOTE:** **Designated Public Hospitals that have a contractual relationship with the LIHP (e.g. Alameda) may include the CPEs of another public agency. These CPEs will be allocated directly to the SNCP and not included in the hospital’s DSH/SNCP cost allocation. Such counties will fill out a separate section on Schedules 2-A1, 3-1, 4 and 5.**

Step 7D is used to estimate the administrative costs related to the HCCI. This section is for information only since these costs are claimed under a separate protocol. The costs are taken from Schedule 2-A1. If the LIHP elects capitation payment, these costs will only include those administrative costs not included in the capitation calculation.

Step 8 is used to calculate the Medi-Cal inpatient and outpatient physician and non-physician practitioner professional fee costs, net of payments received, reimbursable through the Physician SPA. The costs can be volume adjusted. Enter a positive or negative percentage to reflect the effect of anticipated changes in volume for the project year on lines 97 and 110. The State may base Physician SPA interim payments on the results of this step.

Step 9 is for LA County only. It is used to calculate the CBRC costs. Enter the estimated hospital OP visits for the projected year on line 125. Enter the estimated non-hospital visits for the projected year on line 128. The physician professional component costs can be volume adjusted. Enter a positive or negative
percentage to reflect the effect of anticipated changes in volume for the projected year on line 131. This step is for information only since CBRC claims are settled separately.

Step 10 reports costs paid for inpatient services provided to state prison inmates who are eligible for the Medicaid Coverage Expansion (MCE) program. Payments were made to the hospital where services were provided. These costs, incurred by the State, can be claimed by the county of residence for those inmates enrolled in that county’s MCE program. The claim is based on the certification provided by the California Department of Corrections and Rehabilitation (CDCR) or the California Prison Health Care Services (CPHCS) that it has incurred the expense (CPE). The FFP related to these costs is paid directly to the CDCR by the State.

Step 11 is used to calculate the costs for the Medicaid Coverage Expansion (MCE) Program under cost based reimbursement. The projected costs are taken from Schedule 2-A1. These costs are not subject to budget neutrality and are reimbursed at the applicable FMAP rate. If the LIHP elects a capitation rate based reimbursement method, the shortfall or payments in excess of cost for hospital DSH eligible services are used in the DSH-only calculation as described in instructions for Schedule 2.

Step 11A summarizes CPE based medical (non-mental health) costs.

Step 11B summarizes CPE based mental health costs.

Step 11C summarizes those costs always CPE based.

Step 11D summarizes inpatient costs for State Prisoners.

Step 11E summarizes inpatient costs for County Jail Prisoners.

Step 11F summarizes MCE administrative costs. These costs will exclude those costs considered in the capitation calculation.

Step 12 summarizes the DSH-only, DSH/SNCP, and SNCP-only costs that are used in the distribution model.

**Schedule 2-A1.**

The purpose of this schedule is to allow detailed projections of the LIHP programs for the projected fiscal year. These data will be used by the State for calculating interim LIHP payments for the HCCI and MCE programs. The schedule also allows estimates of the cost per member per month to allow comparisons with the capitation payment rates.

**NOTE:** if the effective date of the capitation election is during the ’11-12 fiscal year, please report services rendered from the effective date of the LIHP Contract until the effective date of the actuarially sound capitation rates that are agreed to by DHCS and the Participating Entity and approved by CMS in the section for Services Always CPE Based (see Attachment G – Supplement 2).
The schedule has two major sections, one for the HCCI program and one for the MCE program. Each program is divided into sections for Medical (non-mental health) services, for Mental Health services, and for Services Always CPE Based. The costs for each service component can be adjusted for volume and inflation. The total costs for each service component are converted to costs per member per month to allow comparison with the projected rates if the hospital decides to be reimbursed on a rate basis. The PMPM amounts are calculated separately for the medical program components and the mental health program components.

There is a separate section for designated public hospitals that contract with the LIHP (e.g. Alameda County) for HCCI non-hospital costs. This is required to obtain the amounts for non-hospital CPEs that can be available only for the Safety Net Care Pool.

Please note that the schedule is designed to start with the HCCI and MCI data from the fiscal year reported on Schedules 2.1 and 2.1A. For FY ’11-’12, this is eight month data from FY ’10-’11 annualized. If no data were reported in that fiscal year, or if the data did not include 8 months, please override the formulas to input projected data for the ‘11-’12 fiscal year. The override can be done at the level of detail available to the hospital. For example the estimated cost per visit for services for the current fiscal year can be input in Column I or Q and then adjusted by the expected visits for the projected year and by an inflation adjustment, or, the estimated cost could be input in Column K or S. If those costs were the inflated costs for the projected year, then Column L would remain 0. The cells that can be used to override the formulas are highlighted on the Schedule.

The schedule uses the detail from Schedules 2.1A, 4 and 5 for each component of cost. Input the anticipated days, visits, or units of service for the projected year in Column J. Input as a percentage (format 3.00 for three percent) the inflation adjustment applicable to each cost category in column L. Each cost component can be inflated by a different amount.

For the costs of “other public providers” and for “other funded services”, input a unit of service in column H. If there is no applicable unit of service for these costs, input a “1” in Column H and adjust for volume in Column J by using 1 plus a percentage in the format (1.xx). Input the applicable inflation factor as a percentage in column L (format 3.00 for three percent). Use this input methodology for Purchased Mental Health Services and for Administrative Costs as applicable. For Administrative Costs in Step 7D, input a volume adjustment as a percentage (format .03 for three percent).

For the DSH and SNCP payment model, the amounts from this schedule carry forward to Schedule 2 or Schedule 2-A depending on the type of payment selected (cost or actuarially sound rates). Different payment methods can apply to the medical and mental health programs.

**Schedules 2.1 and 2.1-A**

Schedules 2.1 and 2.1-A are used to calculate the costs for the cost report year. These costs are not trended and will be used in the reconciliation process for the year corresponding to the cost report year.

**NOTE:** Unlike past workbooks, data input is required on these schedules to support the 4-month
extension of DY 5 and the 8 months of DY 6. The applicable costs will be used in the two distribution models covering the two fiscal periods.

Schedule 2.1: Step 1 calculates the Medi-Cal costs adjusted for State Only Medi-Cal costs and Patient Share of Cost Obligations. There is no input required for this step.

Step 2 calculates the Medi-Cal Managed Care, Medi-Cal Psych, Out-of-State Medi-Cal, and another county’s MCE enrollee shortfalls. There is no data input required for this step.

Step 3 calculates the DSH/SNCP and DSH-only costs of services to the uninsured. The total uninsured costs are reduced by the hospital’s SB1732 payments, patient payments, and adjusted by the applicable percentage for services provided to the undocumented (17.79% and 13.95%) to come up with DSH/SNCP costs. The costs applicable to the undocumented are reduced by Section 1011 hospital payments to come up with DSH-only costs. Enter the costs of drugs and supplies provided directly to the uninsured on line 39.

Step 4: Attachment D costs and physician professional component costs are brought forward from Schedules 1A and 1B or 1B-UC. Enter the costs directly allocated to the uninsured for the projected year on lines 60 through 64. These costs include payments for physician services where the payments are specifically identified as payments for services to the uninsured; the costs of drugs provided to the uninsured outside the hospital setting; the cost of securing free drugs for the uninsured; and the costs of hospital services for the uninsured that are purchased from another hospital. If there are additional costs for services provided directly to the uninsured, provide a description and include the costs on Line 64 and the following lines. The total uninsured costs are reduced by patient payments and adjusted by the applicable percentage for services provided to the undocumented (17.79% and 13.95%) to come up with SNCP costs.

*Step 5 summarizes the Medi-Cal costs for the extension period and the DSH-only, DSH/SNCP, and SNCP-only hospital costs that are used in the distribution models.*

Schedule 2.1-A is used to calculate anticipated hospital and non-hospital costs, net of payments received, that are eligible for SNCP claiming for the fiscal year.

Step 6 is for calculating the non-hospital SNCP CPEs. Costs and payments are brought from Schedules 4 and 3.1. There is not data input required in this step.

Step 7 is used to calculate uninsured costs related to the Coverage Initiative (CI) for the four-month extension period and to the Health Care Coverage Initiative (HCCI) for the eight month DY 6. The CI and HCCI costs are taken from the Schedules 1, 1A, 1B or 1BUC, and Schedule 4. Patient payments related to the HCCI costs are taken from Schedule 3.1. The schedule is divided into separate sections for medical services (step 7A), mental health services (step 7B), services always CPE based (step 7C) and administrative costs (step 7D).

At step 7C, enter the total CI and HCCI expenditures needed to claim the federal CI and HCCI allotments; this is your federal allotment divided by the appropriate FMAP for the costs being reported. (In State FY
10-11, the FMAP is 61.59% from 7/1/10-12/31/10, 58.77% from 1/1-3/31/11 and 56.88% from 4/1-6/30/11.)

Costs in excess of the allotment are included as DSH/SNCP costs or SNCP-only costs. These costs will be applied to the CI allotment with the following priority: non-hospital costs, SNCP-only costs (Attachment D and physician costs), outpatient hospital costs, and inpatient hospital costs. For the waiver extension period, inpatient hospital CI costs are included in the stabilization calculation in the distribution model. Hospital inpatient and outpatient costs not applied to the CI are available for DSH costs. All other costs not applied to the CI are available for SNCP costs.

**NOTE: Designated Public Hospitals that have a contractual relationship with the LIHP for the HCCI (e.g. Alameda) may include the CPEs of another public agency. These CPEs will be allocated directly to the SNCP and not included in the hospital's DSH/SNCP cost allocation. Such counties will fill out a separate section on Schedules 3-1, 4 and 5.**

Step 7D is used to report the administrative costs related to the CI and HCCI. This section is for information only since these costs are claimed by a separate protocol. The costs are taken from Schedule 4.

Step 8 is used to calculate the Medi-Cal inpatient and outpatient physician and non-physician practitioner professional component costs, net of payments received, reimbursable through the Physician SPA. For the period from 7-1-10 through 10/31/11 which includes the two-month waiver extension period, FFP reimbursement for inpatient physician costs counts toward the hospitals' guaranteed baseline. The State bases Physician SPA payments on this step. No data input is required.

Step 9 is for LA County only. It is used to calculate the CBRC costs net of patient payments. This step is for information purposes only since CBRC claims are settled separately. No data input is required.

Step 10 reports costs paid for inpatient services provided to state prison Inmates who are eligible for the Medicaid Coverage Expansion (MCE) program. Payments were made to the hospital where services were provided. These services are provided at a hospital other than the enrollee's County of residence hospital the costs incurred by the State can be claimed by the county of residence for those inmates enrolled in that county's MCE program. The claim is based on the certification provided by the California Department of Corrections and Rehabilitation (CDCR) or the California Prison Health Care Services (CPHCS) that it has incurred the expense (CPE). The FFP related to these costs is then paid by the State to the CDCR or CPHCS. No data input is required.

Step 11 is used to summarize the costs related to the 2010 Waiver Medicaid Coverage Expansion (MCE) program. These costs are not subject to budget neutrality and are reimbursed at the applicable FMAP rate. No data input is required.

Step 12 summarizes the Medi-Cal costs for the extension period and the DSH-only, DSH/SNCP, and SNCP-only costs that are used in the distribution models. No data input is required.
Step 13 is for LA County to report the DSH/SNCP and SNCP-only costs that are used to draw down the South LA Fund. This applies only to the extension period. Data input is required.

**Schedule 3**

Schedule 3 is used to calculate the trend factor that is applied to estimate the Medi-Cal interim rate and the DSH and SNCP costs for the year after the cost report year (projected year). The Hospital and Related Services US City Average CPI index is applied to the calculated Medi-Cal cost per day from the fiscal year costs determined in Schedule 1. If necessary, these costs are adjusted for documented hospital-specific circumstances that are not addressed in the CPI adjustment. Enter on lines 17-23, as a positive or negative cost per day, costs expected in the projected year that were not in the fiscal year (positive per day amount) and costs in the fiscal year that are not expected to continue in the projected year (negative per day amount). Add descriptions as necessary. These costs should include new services or reductions in service. Enter on line 24, column H, a CPI inflation factor if the hospital decides that a factor lower than the US City Average CPI provides a more accurate projection. This factor must be lower than the US City Average CPI factor included in the worksheet. These adjustments will be included in the trend factor. The resulting trend factor will be applied to all fiscal year costs for interim payment purposes. Since only one FMAP applies to fiscal year 2011-2012, the trend factor will be calculated in the aggregate for the entire year. For the interim rate calculation on Schedule 2 and the Medi-Cal cost calculation on Schedule 2.1, the cost per day is reduced by the revenue per day received or expected to be received for administrative days, carve-out days, and crossover days for QMB+ and SLMB+ individuals. These payments are reported on Schedule 3.1.

**Additional information requested on Schedule 3:**

Enter the State-Only Medi-Cal Percentage provided by the Department of Health Care Services based on paid claims data for hospital and physician costs. If the hospital has only one percentage, please enter it in cells F45, F46, H45, and H46. This percentage is used to reduce Medi-Cal costs on an interim basis on Schedule 2. The percentage will be different when the workbook uses audited Medi-Cal data.

Enter the end dates of the three most recent fiscals years with final audits on line 48. Enter the “as filed” Medi-Cal costs on line 49 and the “audited” Medi-Cal costs on line 50. Enter “as filed” total costs on line 53 and “audited” total costs on line 54. The average percent reduction is used as an adjustment factor in the settlement process.

Enter the numbers of Medi-Cal full dual eligibles, all other Medi-Cal, Out-of-State Medicaid, LIHP (CI, HCCI, and MCE), and uninsured discharges for General Acute, Psych sub-provider, Rehab sub-provider, Other sub-provider (e.g. LTC), and Nursery well baby by fiscal period on lines 66-76. Enter projected discharges for FY 11-12. Medi-Cal discharges include Medi-Cal managed care and Medi-Cal pending that are expected to convert to Medi-Cal. Enter the State-Only Percentage provided by the Department of Health Care Services based on paid claims data. Discharge data is used for the allocation of DSH funds in the DY 6-10 model and for other program purposes.

**Schedule 3.1**
This is a new schedule that provides for input of payment amounts that are used to reduce costs available for CPE claiming. The offsets are carried forward as applicable to Schedules 2 and 3. **NOTE: All payments should be on an accrual basis and relate to the services in the reporting period.** Enter on lines 3-8, by fiscal period, the payments received from the State for administrative days, blood factor payments, Medi-Cal and Medicare payments for full dual eligibles (Medi-Medi), patient share of cost obligations (not payments) for cross-over claims (Medi-Medi), and other carve-out payments needed to offset Medi-Cal costs included in Schedule 1. (Note that Medicare payments for dual eligibles should include the GME add-on amounts and any amounts claimed as Medicare Bad Debts for claims included in columns 1b and 2b of Schedules 1.1.) The total of these payments will be used in the calculation of the interim rate and for settlement of the Medi-Cal entitlement. Enter on line 10 by fiscal period the Medi-Cal share-of-cost charges and on line 11 payments received for share-of-cost obligations.

Lines 15 through 46 are for Medi-Cal managed care, Medi-Cal psych, and Out-of-State Medicaid, and another county’s LIHP enrollee payments. Enter on line 15 by fiscal period, regular Medi-Cal managed care payments, excluding the portion for physician services. Enter on line 16 any Medi-Cal Supplemental Managed Care IGTs by fiscal period. Enter on line 17 by fiscal period the gross amount of corresponding Medi-Cal managed care payments received from the managed care plan(s). Enter on line 18 by fiscal period the amount of the gross Medi-Cal managed care supplemental payments that were allocated to physician services, if any. Line 16 is for memoranda purposes only; the workbook will automatically offset the gross amount minus any physician payments. For 1/1/11 through 6/30/11 only, enter on line 20 by fiscal period the IGT amount used to fund the hospital fee managed care component. Line 20 is for memoranda purposes only. Enter on line 21 by fiscal period the amount of Hospital Fee payments that were received from the managed care plan(s) (the Managed Care Component). (Note: grant payments are not to be included.) The total of these payments will be carried forward to Schedules 2 Projected and 2.1, Step 2, to offset the Medi-Cal managed care shortfall.

Enter on lines 27 and 28 by fiscal period the total payments for inpatient and outpatient hospital psychiatric services. **NOTE: for inpatient and outpatient services, enter at least the total SMA amount paid to the County mental health plan even if the hospital received less than that amount.** Enter on lines 29 and 30 supplemental psych payments from the Mental Health SPA and the psych portion of the hospital fee. **(NOTE: As of the February 17, 2012, the MH SPA has not yet been approved, however it may be approved by the time this workbook is completed. As of February 17, 2012, no hospital fee payments have been made for the Psych component.)** Enter on line 31 payments received from patients for psychiatric services. Enter on line 37 Medicaid payments received for services to Out-of-State Medicaid patients. Enter on line 38 patient payments received from or on behalf of Out-of-State Medicaid patients. Enter on line 43 payments received from another county for their MCE enrollees, on line 44 CDCR or CPHCS payments for prisoners enrolled in another county’s CME program and on line 45 patient payments received from another county’s MCE enrollees including prisoners.

The total of the Psych, Out-of-State Medicaid, and another county’s MCE payments will be carried forward to Schedules 2.1 and 2 Projected, Step 2.
Lines 48 through 64 identify payments that affect the calculation of uninsured costs eligible for DSH and SNCP claiming. Enter all payments by fiscal period. Report payments related to the dates of service.
Enter SB 1732 payments on line 50, patient payments for inpatient and outpatient hospital services on line 51, Section 1011 payments (excluding the physician portion) on line 52, patient payments related to hospital Attachment D and physician professional costs on line 55

**NOTE: be sure to include contract payments received from Counties or County Hospitals for services to specific uninsured patients,**

patient payments for non-hospital OP clinic services on line 59, patient payments for non-hospital mental health outpatient services on line 60, other patient payments for non-hospital services on line 61, and Sections 330 grant payment for FQHC clinics where the costs were not removed prior to cost finding on line 62. Payments should be related to the fiscal year’s dates of service. These payments are used to offset costs on Schedules 2 Projected, 2-A Projected, 2.1 and 2.1-A, Steps 3, 4, and 6.

Lines 65 through 92 identify payments related to the Coverage Initiative (CI) and the Health Care Coverage Initiative (HCCI). The HCCI program may be capitation or CPE based for medical services and/or mental health services. Substance abuse services, services for enrollees otherwise eligible for Ryan White or ADAP funding, and physical medicine services not considered in the capitation rate are always CPE based. This schedule has three sections to reflect these options.

Medical Services: Enter on line 68 patient payments related to the dates of service for hospital services (including mental health services) for the CI and DSH eligible hospital medical services for the HCCI by fiscal period. Enter on line 69 patient payments related to the dates of service for Attachment D and non-hospital services (including mental health services), and payments for physician services for the CI and for Attachment D and non-hospital HCCI medical services, including physician services, by fiscal period. These amounts are carried forward to Schedules 2.1-A and 2-A Projected, Step 7. If the LIHP has elected capitation payments for medical services, enter on line 72 the portion of the capitation payments allocable to DSH eligible hospital HCCI medical services. Enter on line 73 the portion of the capitation payments allocable to Attachment D and non-hospital HCCI medical services, including payments for physician services. These amounts are carried forward to Schedules 2-A Projected, Step 7.

Mental Health Services: Enter on line 78 patient payments related to DSH eligible hospital mental health services for the HCCI by fiscal period. Enter on line 79 patient payments related to Attachment D and non-hospital HCCI mental health services, including physician services, by fiscal period. These amounts are carried forward to Schedules 2.1-A and 2-A Projected, Step 7. If the LIHP has elected capitation payments for mental health services, enter on line 82 the portion of the capitation payments allocable to DSH eligible hospital HCCI mental health services. Enter on line 83 the portion of the capitation payments allocable to Attachment D and non-hospital HCCI mental health services, including payments for physician services. These amounts are carried forward to Schedules 2-A Projected, Step 7.

Services Always CPE Based: Enter on line 88 patient payments related to hospital HCCI services always paid on a CPE basis, including payments for physician hospital services. These include substance abuse services, services to enrollees otherwise eligible for Ryan White or ADAP funding, and physical medicine services not considered in the capitation rate. Enter on line 89 patient payment related to non-hospital HCCI services, including physician non-hospital services, that are always CPE based.
Lines 93 through 126 identify payments for Medicaid Coverage Initiative (MCE) services. The MCE program may be capitation or CPE based for medical services and/or mental health services. Substance abuse services, services for enrollees otherwise eligible for Ryan White or ADAP funding, physical medicine services not considered in the capitation rate and services for specific LIHP enrollees under the MCE component of the program who are eligible only while they are admitted as an in-patient in a medical institution (prisoners) are always CPE based. This schedule has three sections to reflect these options.

Medical Services: Enter on line 96 patient payments related DSH eligible hospital medical services for the MCE by fiscal period. Enter on line 97 patient payments related to the dates of service for non-hospital medical MCE services and payments for physician services, by fiscal period. These amounts are carried forward to Schedules 2.1-A or 2-A Projected, Step 11. If the LIHP has elected capitation payments for medical services, enter on line 100 the portion of the capitation payments allocable to DSH eligible hospital MCE medical services. Enter on line 101 the portion of the capitation payments allocable to non-hospital MCE medical services, and payments for physician services. The DSH eligible amount of patient payments and capitation payments are carried forward to Schedules 2 Projected, Step 2. Enter on line 104 the IGT portion of the rate based payments for Medical Services.

Mental Health Services: Enter on line 106 patient payments related to DSH eligible hospital mental health services for the MCE by fiscal period. Enter on line 107 patient payments related to non-hospital MCE mental health services, including physician services, by fiscal period. These amounts are carried forward to Schedules 2.1-A and 2-A Projected, Step 11. If the LIHP has elected capitation payments for mental health services, enter on line 110 the portion of the capitation payments allocable to DSH eligible hospital MCE mental health services. Enter on line 111 the portion of the capitation payments allocable to non-hospital MCE mental health services, including payments for physician services. The DSH eligible patient payments and capitation payment amounts are carried forward to Schedules 2 Projected, Step 2. Enter on line 114 the IGT portion of the rate based payments for Mental Health Services.

Services Always CPE Based: Enter on line 116 amounts incurred by the State and reported by the California Department of Corrections and Rehabilitation (CDCR) or the California Prison Health Care Service (CPHCS) for payments made to non-prison hospitals other than the LIHP County Hospital for inpatient services provided to prisoners enrolled in the County MCE program. These amounts can be reported based on the CDCR or CPHCS certification that the expenditures were made. The FFP related to these payments will then be paid to the CDCR or CPHCS. These costs are carried forward to Schedule 2.1-A and 2-A, Step 10.

Enter on line 118 payments from the CDCR or CPHCS for inpatient services provided by the LIHP County hospital to prisoners enrolled in the County's MCE program. Enter on line 119 patient prisoner payments related to the dates of service for these MCE services. Enter on line 120 payments from the county or county corrections department for services provided to county jail prisoners at the LIHP County hospital and on line 121 patient county prisoner payments for these MCE services, including payments for physician services. Enter on line 122 patient payments related to hospital MCE services always paid on a
CPE basis, including payments for physician hospital services. These include substance abuse services, services to enrollees otherwise eligible for Ryan White or ADAP funding, and physical medicine services not considered in the capitation rate. Enter on line 123 patient payment related to non-hospital MCE services, including physician non-hospital services, that are always CPE based. These payments are carried forward to Schedules 2.1A and 2-A Projected, step 11 and used to offset MCE costs.

Lines 127 through 171 identify payments related to the Medi-Cal physician professional component costs based on the Physician SPA. Payments should be related to dates of service. Enter on line 129, by fiscal period, Medi-Cal payments for inpatient hospital services (from paid claims). Enter on line 130 patient payments for inpatient hospital professional services. Enter on line 134, by fiscal period, Medi-Cal payments for hospital outpatient professional component services (from paid claims). Enter on line 135 by fiscal period Medi-Cal payments related to inpatient hospital psych professional services (from Mental Health Plan (applicable portion of the SMA) and on line 136 Medi-Cal payments for outpatient hospital psych professional services (from Mental Health Plan (applicable portion of the SMA) on line 136). Enter on line 137 by fiscal period patient share of cost payments related to hospital outpatient professional services. Enter on line 138 by fiscal period patient share of cost payments related to hospital inpatient psych professional services. Enter on line 139 by fiscal period patient share of cost payments related to hospital outpatient psych professional services. Patient payments should be related to dates of service. The total inpatient and outpatient payments are used to offset professional component costs on Schedules 2.1-A and 2-A Projected, Step 8.

Lines 143 through 150 identify payments for Los Angeles County CBRC services. Enter on line 145 patient payments related to dates of service for CBRC hospital outpatient services. Enter on line 146 patient payments related to dates of service for CBRC non-hospital outpatient services. Enter on line 147 patient payments related to dates of service for CBRC physician and non-physician practitioner professional services. The total of these payments is used to offset costs on Schedules 2.1-A and 2-A Projected, Step 9.

Lines 151 through 171 are used to calculate the allowable supplemental payments under the Physician SPA for physician and non-physician practitioner professional services to Medi-Medi Crossover patients (QMB+ and SLMB+). Total payment for these services is limited to Medicare allowable amounts. The costs are brought from Schedules 1B and 1B-UC. Enter on lines 154 and 164 the Medi-Cal professional fee payments for inpatient and outpatient deductible and coinsurance amounts respectively. Enter on lines 155 and 165 Medicare professional fee payments for inpatient and outpatient services respectively. Enter on lines 156 and 166 patient share of cost obligations for inpatient and outpatient professional service claims respectively. Enter on lines 159 and 169 the total amount allowed by Medicare for these inpatient and outpatient services. The amount reimbursable under the Physician SPA is the lesser of the total cost minus total payments, or the Medicare allowable amount minus total payments. The reimbursable amount is carried forward to Schedules 2.1-A and 2-A Projected. Enter on lines 161 and 171 the patient payments received for share of cost obligations for inpatient and outpatient professional service claims respectively. These unreimbursed costs are eligible for SNCP claiming.
Lines 172 through 204 is a separate section for designated public hospitals that contract with the LIHP (e.g. Alameda County) for HCCI non-hospital costs. This is required to obtain the amounts for non-hospital CPEs that can be available only for the Safety Net Care Pool Medical Services: Enter on line 174 patient payments related hospital medical services for the MCE including payments for physician professional services by fiscal period. Enter on line 176 payments received from Alameda County LIHP for hospital medical services. Enter on line 178 patient payments related to the dates of service for non-Hospital HCCI services including payments for physician services, by fiscal period. Enter on line 179 the Alameda County LIHP HCCI allotment for hospital medical services. These amounts are carried forward to Schedules 2.1-A or 2-A Projected, Step 7.

Mental Health Services: Enter on line 185 patient payments related to hospital mental health services for the MCE including payments for physician professional services by fiscal period. Enter on line 187 payments received from the Alameda County LIHP for hospital HCCI mental health services. Enter on line 189 patient payments related to HCCI non-hospital mental health services, including physician services, by fiscal period. Enter on line 190 the Alameda County HCCI Allotment for mental health services. These amounts are carried forward to Schedules 2.1-A and 2-A Projected, Step 7.

Services Always CPE Based: Enter on line 196 patient payments related to hospital MCE services always paid on a CPE basis, including payments for physician and other non-hospital services. These include substance abuse services, services to enrollees otherwise eligible for Ryan White or ADAP funding, and physical medicine services not considered in the capitation rate. Enter on line 198 payments received from the Alameda County LIHP for services that are always CPE based. Enter on line 200 patient payment related to non-hospital HCCI services, including physician non-hospital services, that are always CPE based. These payments are carried forward to Schedules 2.1A and 2-A Projected, step 11 and used to offset HCCI costs.

The Alameda County non-hospital HCCI costs are reduced by the Alameda County HCCI allotment net of the amounts paid to Alameda County Medical Center for hospital services and patient payments for non-hospital services to identify SNCP eligible uninsured costs.

Schedule 4

Schedule 4 is for non-hospital and other costs for care to the uninsured, including Coverage Initiative costs, Health Care Coverage Initiative (HCCI) costs, Medicaid Coverage Expansion (MCE) program costs and for LA County CBRC costs. HCCI and MCE costs are reported in the three categories of medical costs, mental health costs, and costs always reimbursed on a CPE basis. Substance abuse costs are reported on Schedule 5 but are costs that are always CPE based. Please include the Administrative Costs for the CI, HCCI and MCE activities that are to be claimed separately from the operating costs. Note that if an LIHP elects capitation reimbursement for the HCCI or MCE program, the administrative costs include only those costs not considered in the capitation rate calculation. The methodology and forms for reporting and determining these costs for the uninsured have been approved by CMS. Please use the cost per visit information calculated on the non-hospital clinic cost report forms provided by the State and enter the uninsured visits on the appropriate lines of Schedule 4. Also include the costs incurred by the County for
services to the uninsured on lines 23-31 of Schedule 4. For LA County, please include the visit information for uninsured costs related to the CBRC SPA.

1. Non-hospital costs for the uninsured that can be claimed against the Safety Net Care Pool (SNCP) include costs from freestanding clinics (FQHC and non-FQHC clinics, public health clinics, and mental health clinics). These costs should include the cost of physician services since they are SNCP-only costs. Please provide the approved Clinic Cost Reports with the appropriate backup. Mental Health costs are based on the Medi-Cal Short Doyle cost report and are reported on Schedule 5. Enter the cost per unit and the uninsured, CI, HCCI, MCE, and CBRC units by fiscal period. Designated public hospitals that contract with the LIHP (e.g. Alameda County) can include unreimbursed HCCI non-hospital costs as SNCP eligible costs. ACMC will report those costs in columns T through AA on schedule 4.

2. In addition to the costs listed in item 1, additional costs for medical services provided to the uninsured are claimable against the SNCP (see Attachment F, Supplement 6, Contract Cost Claiming Protocol). These include hospital and county payments to private providers for trauma services at non-county hospital, emergency services at non-county hospital, physician trauma and emergency services, outpatient clinic medical services for the uninsured that the county cannot provide due to lack of capability or capacity. These costs should include the cost of physician services since they are SNCP-only costs. Enter a description of the service and the costs on the appropriate lines by fiscal period for the uninsured, the CI, HCCI, and MCE programs. For LA County, enter the cost per unit and the Medi-Cal units at non-hospital clinics paid under the CBRC program.

**Schedule 5**

Schedule 5 reflects the mental health payment protocol being considered by CMS. This schedule calculates the uninsured costs for psychiatric services not included in the hospital cost report. This schedule uses cost data from the Short Doyle cost report per Attachment F, Supplement 4 that has been approved through the 2005 waiver. Note: The methodology and form for reporting and determining these costs have not yet been approved by CMS as of February 17, 2012, but Schedule 5 reflects the proposed protocol. Please complete this schedule for uninsured costs, coverage initiative (CI) costs, health care coverage initiative (HCCI) costs and Medicaid Coverage Expansion (MCE) program costs. Enter Alcohol and Drug cost per unit from the Alcohol and Drug Cost Report, and CI, HCCI, and MCE units as appropriate. Designated public hospitals that contract with the LIHP (e.g. Alameda County) can include unreimbursed HCCI non-hospital costs as SNCP eligible costs. ACMC will report those costs in columns AC through AAH on schedule 5.

Section 1: Using the Short Doyle cost report submitted for the County Mental Health Services provided by the County, supply the applicable service function and cost per unit for each service function. Provide source worksheets for any modes or service functions not included in the table. Enter the units of service by fiscal period applicable to the uninsured, the CI, the HCCI, and the MCE programs. Designated public hospitals that contract with the LIHP (e.g. Alameda County) can include unreimbursed HCCI non-hospital costs as SNCP eligible costs. ACMC will report those costs in columns AC through AH on schedule 5. The costs are carried forward to Schedule 4.
Section 2: For each provider from whom the County purchases services for the uninsured, please complete the following: provider name, amount paid to the provider for services to the uninsured, and the units of service by mode for each service function. Please insert the mode and service function where applicable. Enter these data for the uninsured, the CI, the HCCI and the MCE programs. Designated public hospitals that contract with the LIHP (e.g. Alameda County) can include unreimbursed HCCI non-hospital costs as SNCP eligible costs. ACMC will report those costs in columns V through AO on schedule 5. The costs are carried forward to Schedule 4.