Global Payment Program

Aggregate Reporting Submission Guide

Participating public health care systems (PHCS) are required as part of the Global Payment Program (GPP) to submit aggregate GPP service and points data in accordance with the Special Terms and Conditions, Attachment EE.

For each GPP program year (PY), PHCS are required to submit the following:

- By August 15th following the close of each GPP PY, an interim year-end report summarizing the aggregate number of uninsured units of services provided during the GPP PY.
- By March 31st following the close of each GPP PY, a final year-end reconciliation summary report in the same format as the interim year-end summary report that includes the PHCS final submission with regard to the services, points, and funds earned for the GPP PY. The final reconciliation summary report shall reflect any necessary revisions to the interim data and shall serve as the basis for the final reconciliation of GPP payments for the GPP PY.

Data submission – In completing the interim and final report, please follow the following instructions:

In cell B2, please choose the reporting type (interim or final) from the dropdown menu.

In cell B3, please choose the PHCS. This will auto-populate the report with the PHCS's global budget and threshold for the PY.

For each service type, please enter the number of uninsured days or units in column D. For contracted emergency services, amounts that were paid through Maddy Funds in accordance with Health and Safety Code section 1797.98a-1797.98g, PHCS should convert those dollar amounts into visits by taking the amount expended on uninsured services and dividing by $411 (cost of the average contracted ER visit used in the initial point threshold development) to obtain the number of visits reportable in cell D16. Other contracted ER services should be reported separately in cell D17.

For non-traditional services, from row 26-58, please refer to STC attachment FF for the definition of each non-traditional service. Note that non-traditional services can only be claimed if the individual is uninsured for the traditional service for which the non-traditional service is being used as a substitute. For example, if the individual has coverage for primary care visits, then they cannot claim any non-traditional visits that substitute for primary care visits such as telehealth, group medical visits, telephone consultation, etc.

Cells B61:B65 calculate each PHCS's total points earned, percentage of threshold met, and the amount of gross GPP budget earned. Note that the worksheet limits the earnable amount at 100% of budget as that is the maximum of each PHCS's own budget that can be earned. In the final reconciliation, PHCS

which exceed their threshold may be able to earn unclaimed budget amounts from other PHCS, which will be calculated separately.