CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

FST - Claiming, Reporting, & Revenue Maximization

Module 3

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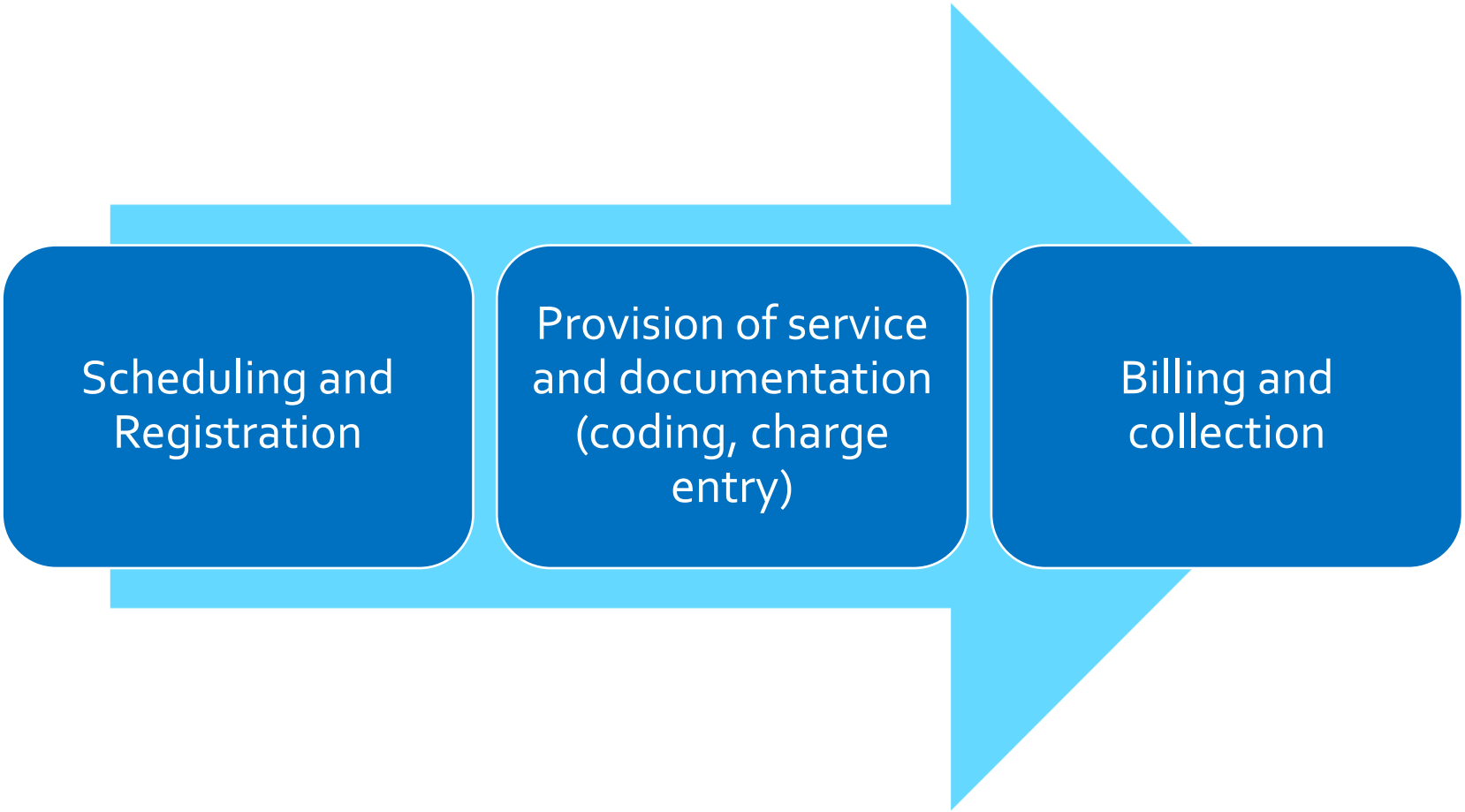
Agenda

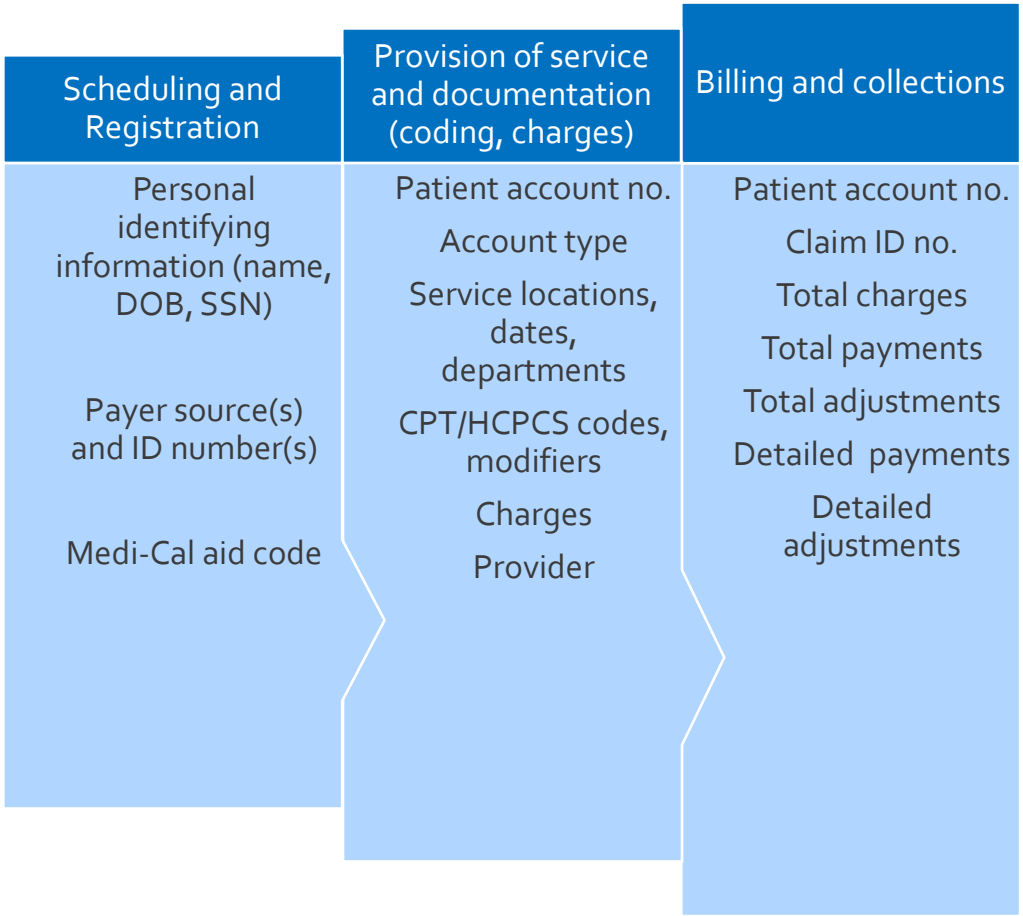
- Understand how multiple data systems interconnect and contribute to claiming
  - Analysis and problem-solving
- Key inputs for and outputs of Medi-Cal Cost Report
- Major sections of and outputs of P14 Workbook
- Importance of mapping
- Payments linked to these sources
  - FFS IP
  - AB915 and PNPP
  - DSH/SNCP (historical except UCs)

Your Data Systems

Revenue cycle components



Revenue cycle components



Questions about your revenue cycle data

- How much can staff autopopulate from prior data when registering a patient?
- How do you handle multiple surnames?
- How frequently is Medi-Cal eligibility verified?

Medi-Cal coverage specifics the system should encompass

- Responsible payer
- Share of cost responsibility, if any
- Aid code
- Denials affecting coverage
- State-only status

Feedback loops

How does your system prompt action when…

- A patient belatedly submits information qualifying them for charity care policy?
- A patient returns for a follow-up visit and their aid code has transitioned from Hospital Presumptive Eligibility to Full-Scope Medi-Cal?

Reporting and workbooks

What is a cost report and how does it differ from a P14?

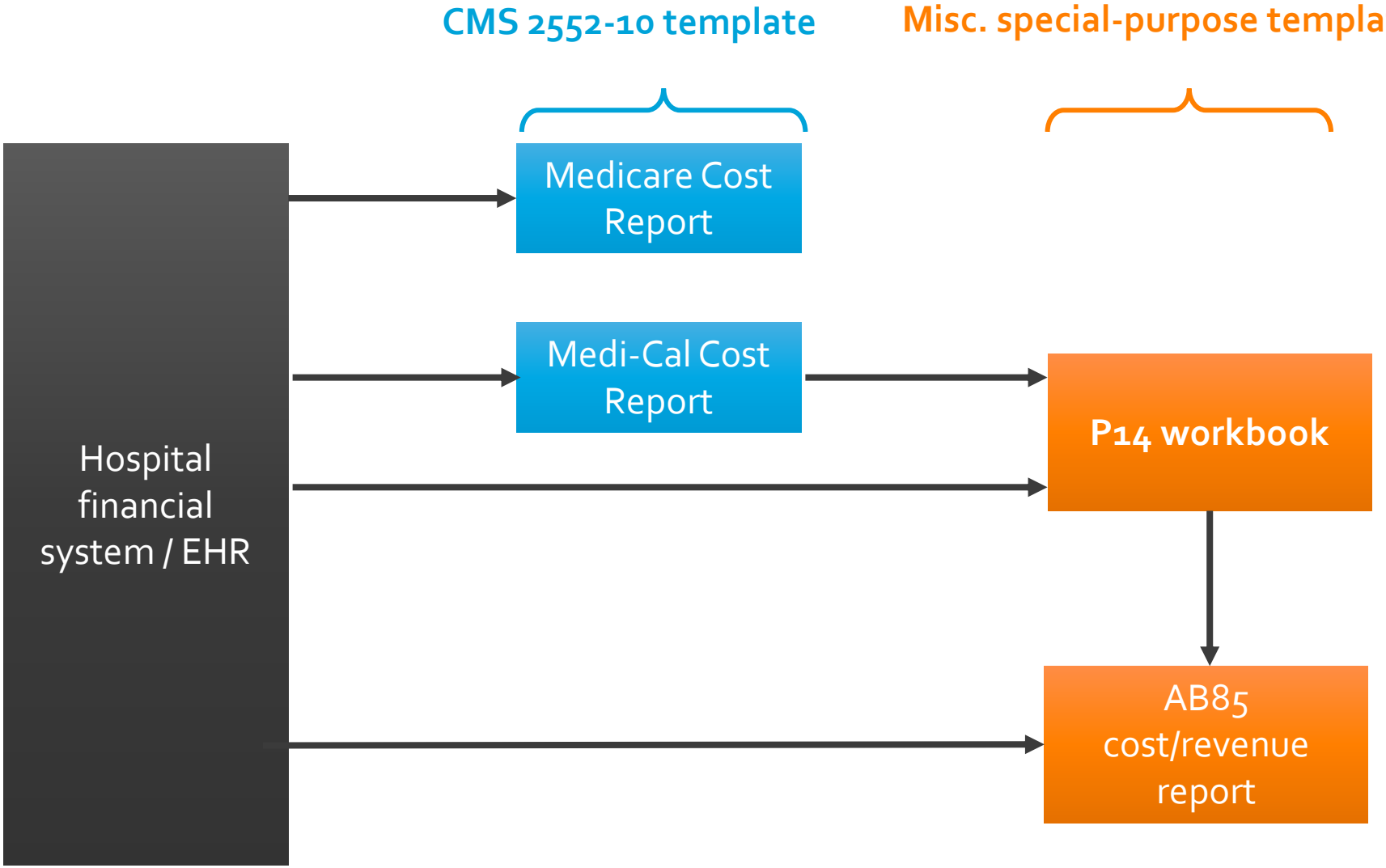
Cost report:

- Originally designed to support cost-based reimbursement for hospitals in Medicare/Medi-Cal (when such reimbursement was more common)
- Follows governmental reimbursement principles – separates reimbursable from non-reimbursable, etc.
- Allows separation of costs by payer – broadly
- Usually transmitted in its own electronic format

P14 workbook:

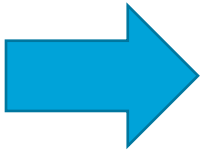
- Named for "Paragraph 14" of 2005 waiver terms & conditions
- For DPHs only
- Developed and maintained by DHCS/CAPH
- Separates services by payer more finely than cost report, but using the same principles
- Excel format

Report/Workbook Flow



Cost reporting by cost center

Costs From General Ledger



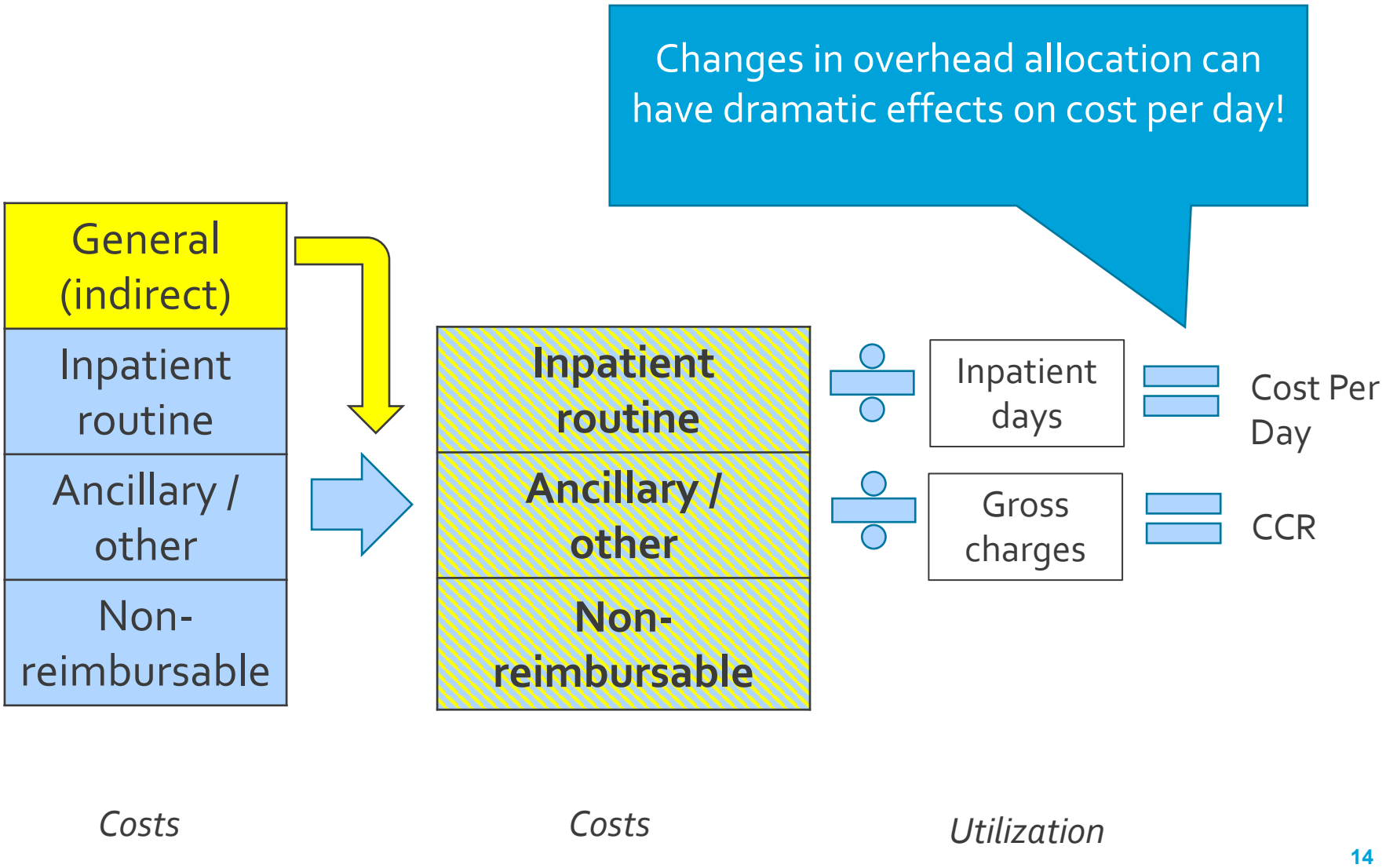
Cost Center	CMS 2552-10 cost center rows
General (indirect)	00100~02900
Inpatient routine	03000~04900
Ancillary / other	05000~11600
Non-reimbursable	19000

Allocating indirect costs to direct cost centers

- Indirect costs need to be allocated to revenue-producing cost centers using appropriate "drivers" such as
  - Square feet
  - Gross salaries
  - Gross revenue
- Example: Allocating $100,000 housekeeping costs to three areas

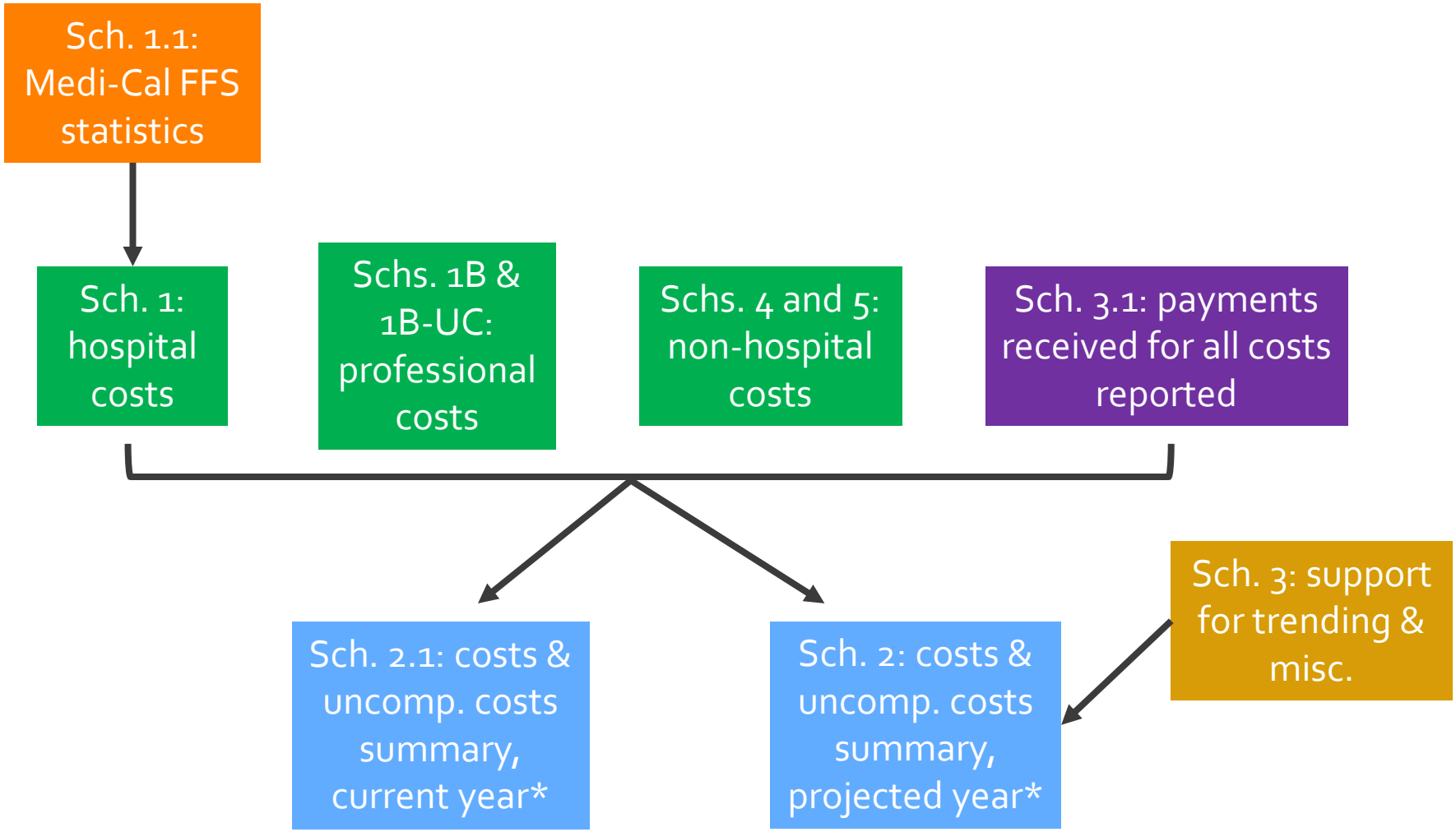
Cost Center Groups	Driver: Square Feet	Allocation Rate	Cost Allocated
IP	500	50%	$50,000
OP	300	?	?
Ancillary	200	?	?

Key outputs of cost report (for our purposes)



From cost report to P14

Structure of P14 schedules (tabs)



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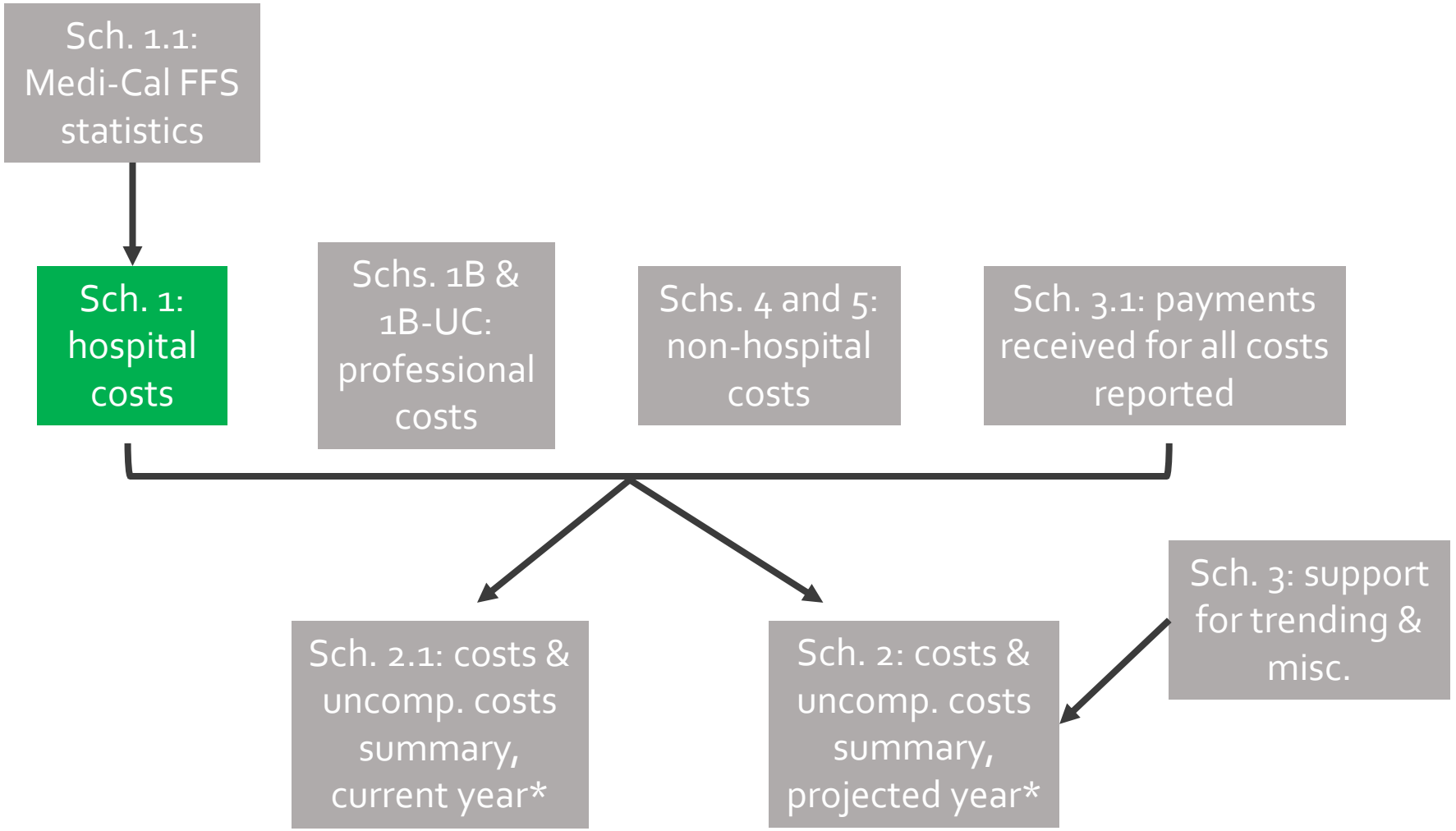
Structure of P14 schedules (tabs)



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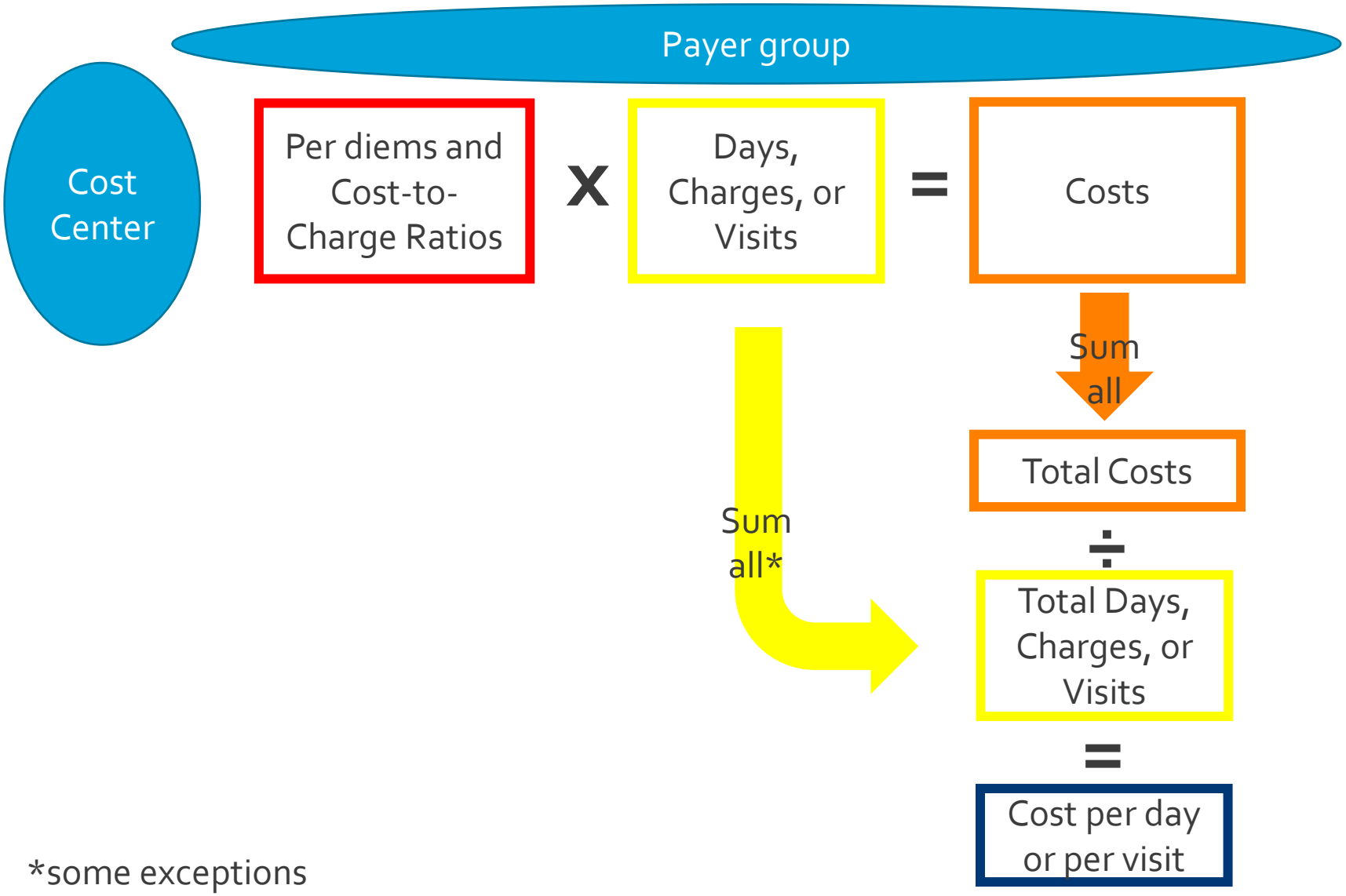
Schedule 1: Key cost statistics

Line Num	Cost Center Description (Revise as needed)	Hospital Per Diems and Cost to Charge Ratios From Applicable Fiscal Year "as filed and accepted" applicable Medi-Cal Cost Report
03000	ADULTS & PEDIATRICS (GENERAL ROUTINE CARE)	2,793.09
03100	INTENSIVE CARE UNIT	5,413.83
03200	CORONARY CARE UNIT	6,005.80
03300	BURN INTENSIVE CARE UNIT	6,334.04
03400	SURGICAL INTENSIVE CARE UNIT	4,574.78
03500	NEONATAL INTENSIVE CARE UNIT	5,062.85
03501	PEDIATRIC INTENSIVE CARE UNIT	11,506.99
03502	TRAUMA INTENSIVE CARE UNIT	5,594.05
04000	**SUBPROVIDER - IPF (from Subprovider D-1)**	2,889.46
04300	NURSERY	1,424.73
04400	SKILLED NURSING FACILITY	-
04500	NURSING FACILITY	
04600	OTHER LONG TERM CARE	-
05000	OPERATING ROOM	0.277740
05200	DELIVERY ROOM & LABOR ROOM	0.705098
05300	ANESTHESIOLOGY	0.160897
05400	RADIOLOGY-DIAGNOSTIC	0.285129
05401	ULTRA SOUND	0.244224

The cost per diems, by inpatient unit

The cost-to-charge ratios, by ancillary cost center

Schedule 1: Days, Charges to Costs



*some exceptions

Days and charges to costs, by P14 payer group (1)

			Medi-Cal FFS Pre ACA Eligible		Medi-Cal FFS New Eligible (July - December)		Medi-Cal FFS New Eligible (January - June)	
			Medi-Cal FFS Inpatient					
	PLEASE FILL IN THE ORANGE HIGHLIGHTED CELLS	1	2a	2b	2a1	2b1	2a2	2b2
		3				8	9	10
Line Num	Cost Center Description (Revise as needed)	Hospital Per Diems and Cost to Charge Ratios From Applicable Fiscal Year "as filed and accepted" applicable Medi-Cal Cost Report	Medi-Cal FFS Days and IP Charges from "as filed and accepted" applicable Fiscal Year Medi-Cal Cost Report (Include Admin & Carve-out data) *From Schedule 1.1*	Medi-Cal Costs Inpatient *Col. 1 * Col 2a*	Medi-Cal FFS Days and IP Charges from "as filed and accepted" applicable Fiscal Year Medi-Cal Cost Report (Include Admin & Carve-out data) *From Schedule 1.1*	Medi-Cal Costs Inpatient *Col. 1 * Col 2a1*	Medi-Cal FFS Days and IP Charges from "as filed and accepted" applicable Fiscal Year Medi-Cal Cost Report (Include Admin & Carve-out data) *From Schedule 1.1*	Medi-Cal Costs Inpatient *Col. 1 * Col 2a2*
03000	ADULTS & PEDIATRICS (GENERAL ROUTINE CARE)	2,793.09	9,836	27,473,267	3,032	8,469,666	2,555	7,135,328
03100	INTENSIVE CARE UNIT	5,413.83	320	1,729,991	143	775,652	154	832,578
03200	CORONARY CARE UNIT	6,005.80	181	1,086,497	124	742,356	71	429,085
03300	BURN INTENSIVE CARE UNIT	6,334.04	203	1,286,034	155	981,777	41	259,696
03400	SURGICAL INTENSIVE CARE UNIT	4,574.78	161	734,851	119	545,308	56	254,688
03500	NEONATAL INTENSIVE CARE UNIT	5,062.85	2,663	13,482,362	22	111,383	13	65,817
03501	PEDIATRIC INTENSIVE CARE UNIT	11,506.99	317	3,643,439	0	19	0	38
03502	TRAUMA INTENSIVE CARE UNIT	5,594.05	101	565,369	101	562,545	52	293,465
04000	**SUBPROVIDER - IPF (from Subprovider D-1)**	2,889.46						
04300	NURSERY	1,424.73	2,323	3,309,639	78	111,129	86	122,526
A	Total Costs			79,687,367		21,673,910		
B	Total Days or Visits (See Instructions) (Medi-Cal FFS From Schedule 1.1 Col 1, New Eligible Col 2,Dual Eligible Col 1g)			11,594		3,408		
C	Cost Per Day or Per Visit			6,873		6,360		

Days and charges to costs, by P14 payer group (2)

Medicare/Medi-Cal Dual Eligible Costs *(Not in FFS Claim)*				Medi-Cal Hospital FFS FQHC Costs			
Inpatient			Outpatient (Including FQHC)	Pre ACA Eligible Outpatient		New Eligible Outpatient	
2c	2d		2e	2f	2g	2h	2i	2j
12	13	#	15	16	18	19	20	21
Dual Eligible Inpatient Days & Charges for Claims with no Medi-Cal Payment Obligation *From Schedule 1.1*	**Dual Eligible Inpatient Costs for Claims with no Medi-Cal Payment Obligation** *Col 1*Col 2c*		**Dual Eligible Outpatient Charges for Claims with no Medi-Cal Payment Obligation** *From Schedule 1.1*	**Dual Eligible Outpatient Costs for Claims with no Medi-Cal Payment Obligation** *Col 1*Col 2e*	**Medi-Cal Hospital FFS FQHC Charges (excluding physician)** *From Provider Records*	**Medi-Cal Hospital FFS FQHC Costs (excluding physician)** *Col 1 * Col 2g*	**Medi-Cal Hospital FFS FQHC Charges for New Eligibles (excluding physician)** *From Provider Records*	**Medi-Cal Hospital FFS FQHC Costs for New Eligibles (excluding physician)** *Col 1 * Col 2i*
779	2,174,717							
54	292,911							
13	77,958							
9	57,185							
41	186,146							
-	-							
-	-							
37	204,235							
1	1,425							

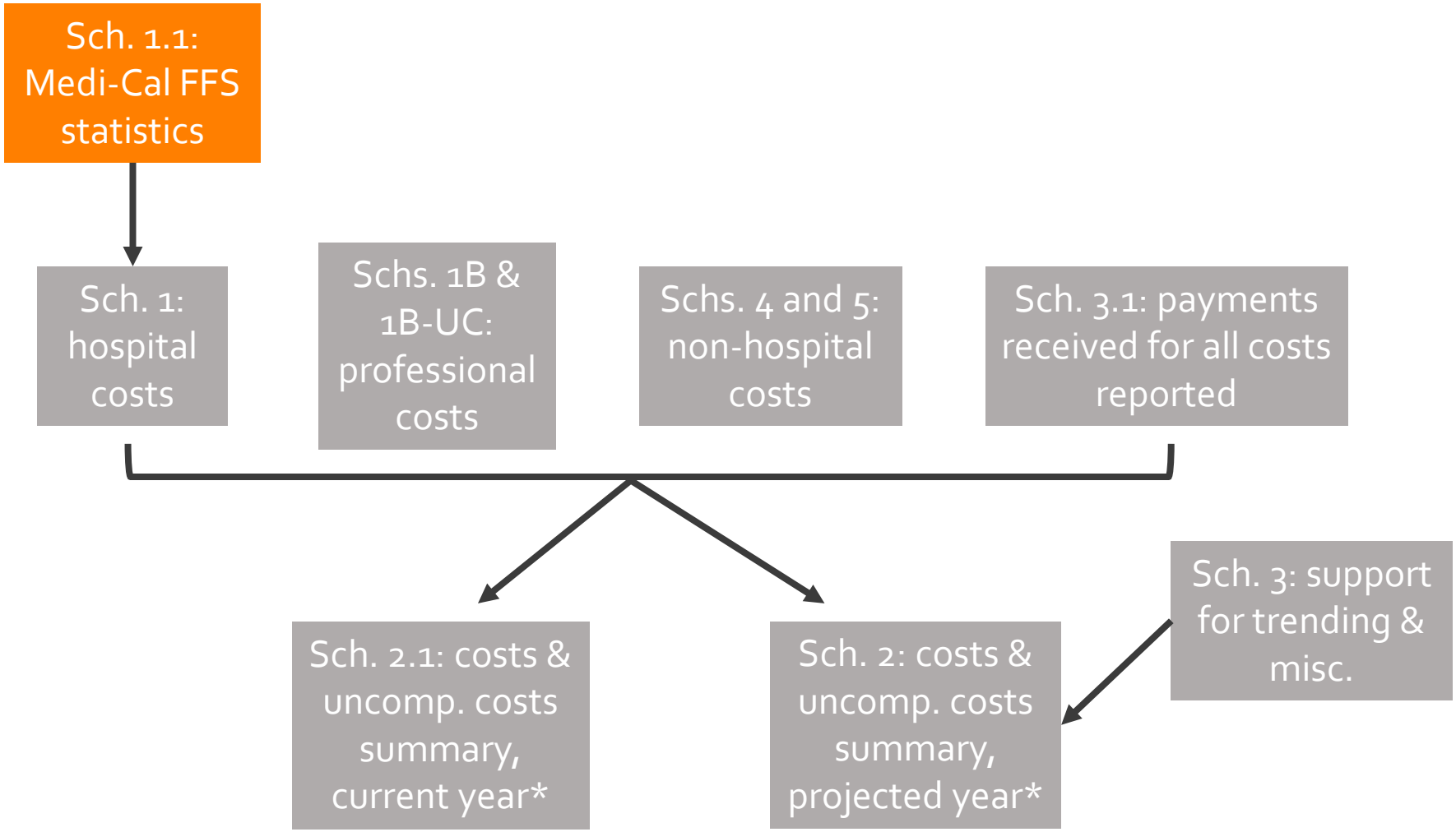
Days and charges to costs, by P14 payer group (3)

Medi-Cal Managed Care Pre-ACA Eligible Inpatient				Medi-Cal Managed Care Pre-ACA Eligible Outpatient (Including FQHC)				Medi-Cal Managed Care Costs New Eligibles			
Dual Eligible Pre-ACA Inpatient		Non-Dual Pre-ACA-eligible Inpatient		Dual Eligible Pre-ACA Outpatient		Non-Dual Pre-ACA-eligible Outpatient		New Eligible Inpatient		New Eligible Outpatient (Including FQHC)	
3a1	3b1	3a2	3b2	3c1	3d1	3c2	3d2	3e	3f	3g	3h
23	24	26	27	29	30	32	33	35	36	38	39
Medi-Cal Dual Eligible pre-ACA Managed Care Days and IP Charges *From Provider Records*	Medi-Cal Dual Eligible pre-ACA Managed Care IP Costs *Col.1*Col3a1*	Medi-Cal Other pre-ACA-eligible Managed Care Days and IP Charges *From Provider Records*	Medi-Cal Other pre-ACA-eligible Managed Care IP Costs *Col.1*Col3a2*	Medi-Cal Dual Eligible pre-ACA Managed Care OP Charges (Including FQHC) *From Provider Records*	Medi-Cal Dual Eligible pre-ACA Managed Care OP Costs (Including FQHC) *Col.1*Col3c1*	Medi-Cal Other pre-ACA-eligible Managed Care OP Charges (Including FQHC) *From Provider Records*	Medi-Cal Other pre-ACA-eligible Managed Care OP Costs (Including FQHC) *Col.1*Col3c2*	Medi-Cal Managed Care Days and IP Charges *From Provider Records*	Medi-Cal Managed Care Inpatient Costs *Col. 1 * Col 3e*	Medi-Cal Managed Care OP Charges (Including FQHC) *From Provider Records*	Medi-Cal Managed Care Outpatient Costs (Including FQHC) *Col. 1 * Col 3g*
14,284	39,895,188	23,499	65,635,534					16,786	46,885,584		
1,011	5,471,346	1,108	5,998,970					618	3,345,744		
538	3,232,492	502	3,014,909					350	2,102,029		
175	1,111,436	288	1,824,204					422	2,672,966		
540	2,469,365	328	1,500,527					553	2,529,853		
-	-	637	3,225,034					11	55,691		
-	-	201	2,312,905					-	-		
217	1,214,593	233	1,303,414					344	1,924,354		
-	-	-	-					-	-		
-	-	2,321	3,306,789					232	330,536		

Days and charges to costs, by P14 payer group (4)

Uninsured				Uninsured Psych and Substance Use			
Inpatient		Outpatient (Including FQHC)		Inpatient Psych		Outpatient Psych *(including FQHC)*	
6a	6b	6c	6d	6g	6h	6i	6j
65	66	68	69	71	72	74	75
Uninsured Days and IP Charges *From Provider Records*	Uninsured Inpatient Costs *Col. 1 * Col 7a*	Uninsured OP Charges (Including FQHC) *From Provider Records*	Uninsured Outpatient Costs (Including FQHC) *Col. 1 * Col 7c*	Uninsured Psych Days and IP Charges *From Provider Records*	Uninsured Psych Inpatient Costs *Col. 1 * Col 7g'*	Uninsured Psych OP Charges *From Provider Records*	Uninsured Psych Outpatient Costs *Col. 1 * Col 7i*
7,973	22,269,580						
183	990,730						
95	570,551						
141	893,100						
200	916,694						
558	2,825,069						
44	506,308						
128	716,039						
				1,353	3,909,443		
470	669,621						

Structure of P14 schedules (tabs)



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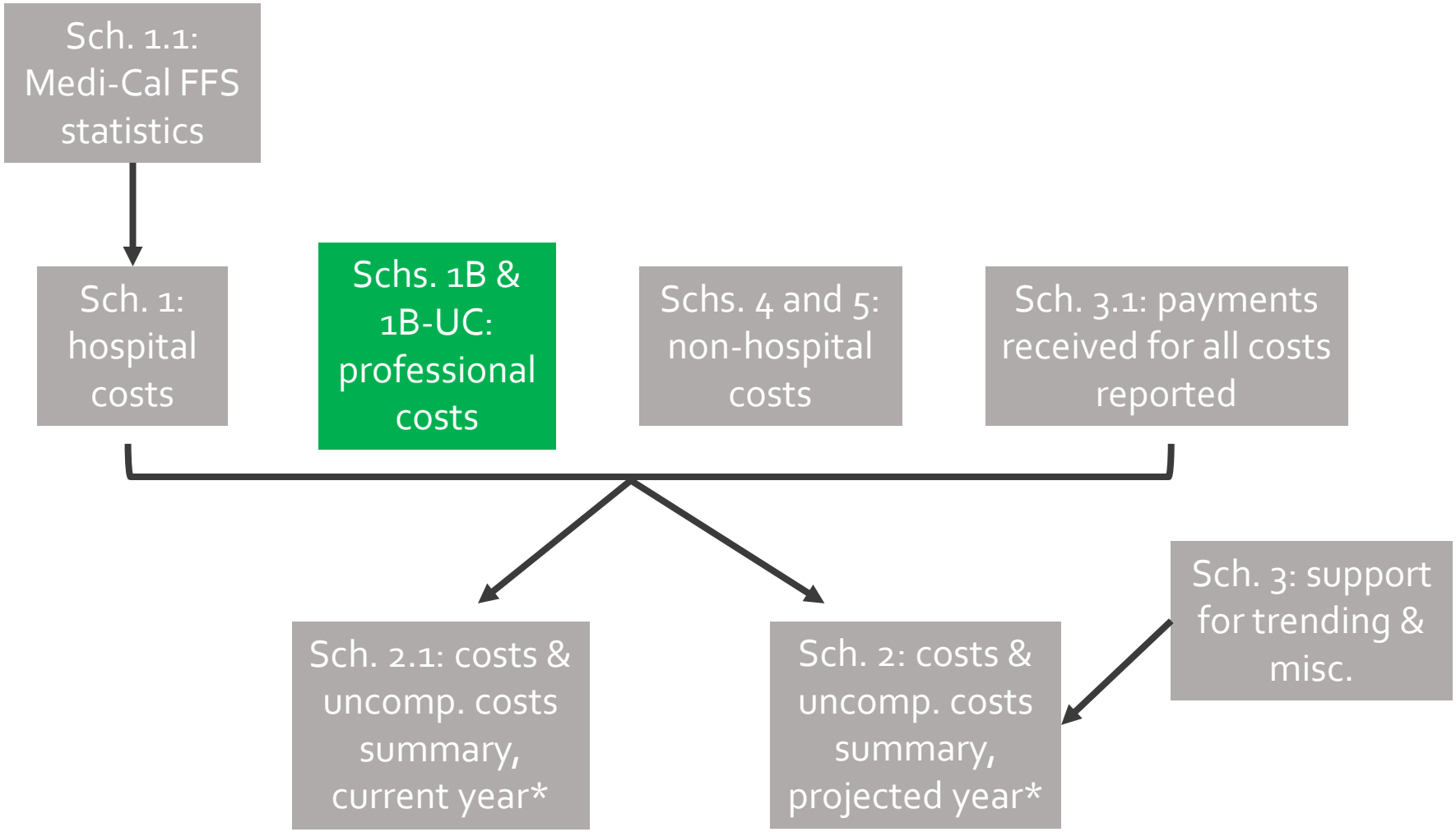
Schedule 1.1: FFS IP

- Even more detail to get eligible FFS IP days

		Medi-Cal FFS Days and IP Charges from "as filed and accepted" applicable Fiscal Year Medi-Cal Cost Report (Include Admin & Carve-out data) *[Worksheets S-3 Part I Column 5 Lines 1-11 column 2, Worksheet D-3 Title V lines 50-98*						
	PLEASE FILL IN ORANGE HIGHLIGHTED CELLS	**1**	**1a**	**1b**	**1c**	**1d**	**1e**	**1f**
Line Num	Cost Center Description (Revise as needed)	Medi-Cal FFS	Well Baby	Medicare /Medi-Cal Dual Eligible *(QMB+SLMB+)*	Administrative	Carve Out	Less adjustment for Hospital Acquired Conditions (HAC)	Total for Schedule 1, Column 2a
		Days	Days	Days	Days	Days	Days	Days
03000	LTS & PEDIATRICS (GENERAL ROUTINE CARE)	7,798		1,500	538		-	9,836
03100	NSIVE CARE UNIT	232		88			-	320
03200	CORONARY CARE UNIT	140		40			-	181
03300	BURN INTENSIVE CARE UNIT	189		14			-	203
03400	SURGICAL INTENSIVE CARE UNIT	118		43			-	161
03500	NEONATAL INTENSIVE CARE UNIT	2,663		-			-	2,663
03501	PEDIATRIC INTENSIVE CARE UNIT	317		-			-	317
03502	TRAUMA INTENSIVE CARE UNIT	85		16			-	101
04000	**SUBPROVIDER - IPF (from Subprovider D-1)**	-						
04300	NURSERY	52	2,271				-	2,323
B	**Total Days for Line B Column 2a Schedule 1**	11,594						
*	Nursery days for Medi-Cal FFS excludes well baby and Mother/baby common days.							
	Subtotal Inpatient Days by Category For Information		2,271	1,701	538		-	16,104

Structure of P14 schedules (tabs)



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Schedule 1B or 1B-UC: Prof. Costs

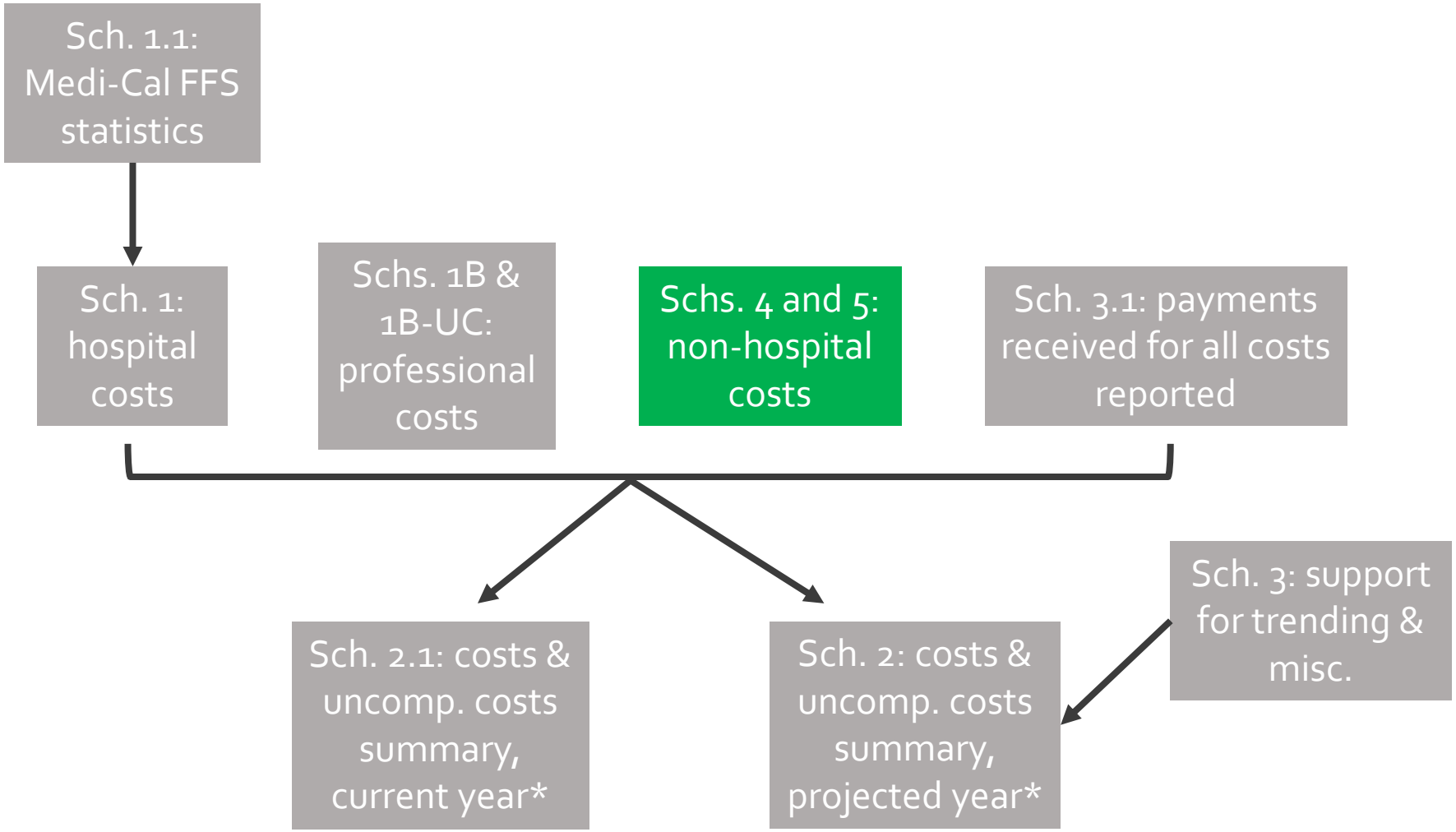
- Similar procedure to Schedule 1 to get to professional costs
- Primarily for calculating PNPP, cost-based reimbursement in FFS

PLEASE FILL IN THE ORANGE HIGHLIGHTED CELLS

Physician Professional Component Costs And Charges

	PART I Physician Costs	1	2	3	4	5	6	7a	7b
ıe Num	Cost Center Description (Revise as needed)	Physician Professional Component Costs (From WS A-8-2 col. 4)	Physician and Non-Physician Practitioner Professional Component Costs (From WS A-8)	Physician Professional Component Related Data Processing, and Patient Business Office Costs (From WS A-8)	Total Physician Professional Component Related Costs (Sum cols. 1-3)	Total Physician Billed Professional Charges (From Provider Records)	Physician Professional Costs to Billed Professional Charges Ratio (col 4 / col 5)	Medi-Cal FFS Pı — Inpatient: Medi-Cal IP Professional Billed Charges *From Provider Records*	Medi-Cal Inpatient Physician Costs *Col. 6 * Col 7a*
03000	ADULTS & PEDIATRICS (GENERAL ROUTINE CARE)	7,876,316	706,219	1,096,774	9,679,310	71,819,152	0.1348	6,897,311	929,574
03100	INTENSIVE CARE UNIT	405,809	69,505	109,777	585,091	7,188,443	0.0814	279,845	22,777
03200	CORONARY CARE UNIT	257,433	45,266	71,494	374,193	4,681,580	0.0799	91,934	7,348
03300	BURN INTENSIVE CARE UNIT	124,927	26,972	42,601	194,500	2,789,582	0.0697	125,561	8,755
03400	SURGICAL INTENSIVE CARE UNIT	121,455	38,232	60,384	220,070	3,954,061	0.0557	112,863	6,282
03500	NEONATAL INTENSIVE CARE UNIT	1,495,249	34,166	53,963	1,583,378	3,533,583	0.4481	1,691,035	757,743
03501	PEDIATRIC INTENSIVE CARE UNIT	434,433	16,707	26,388	477,528	1,727,921	0.2764	746,592	206,328
03502	TRAUMA INTENSIVE CARE UNIT	119,429	35,403	55,916	210,748	3,661,531	0.0576	121,719	7,006
04000	**SUBPROVIDER - IPF (from Subprovider D-1)**	2,155,424	210,370	36,519	2,402,313	2,391,355	1.0046		
04300	NURSERY	295,724	167	264	296,156	17,303	17.1159	5,049	86,421
04400	SKILLED NURSING FACILITY	-	-	-	-	-	-		
04500	NURSING FACILITY	-	-	-	-	-	-		
04600	OTHER LONG TERM CARE	-	-	-	-	-	-		

Structure of P14 schedules (tabs)



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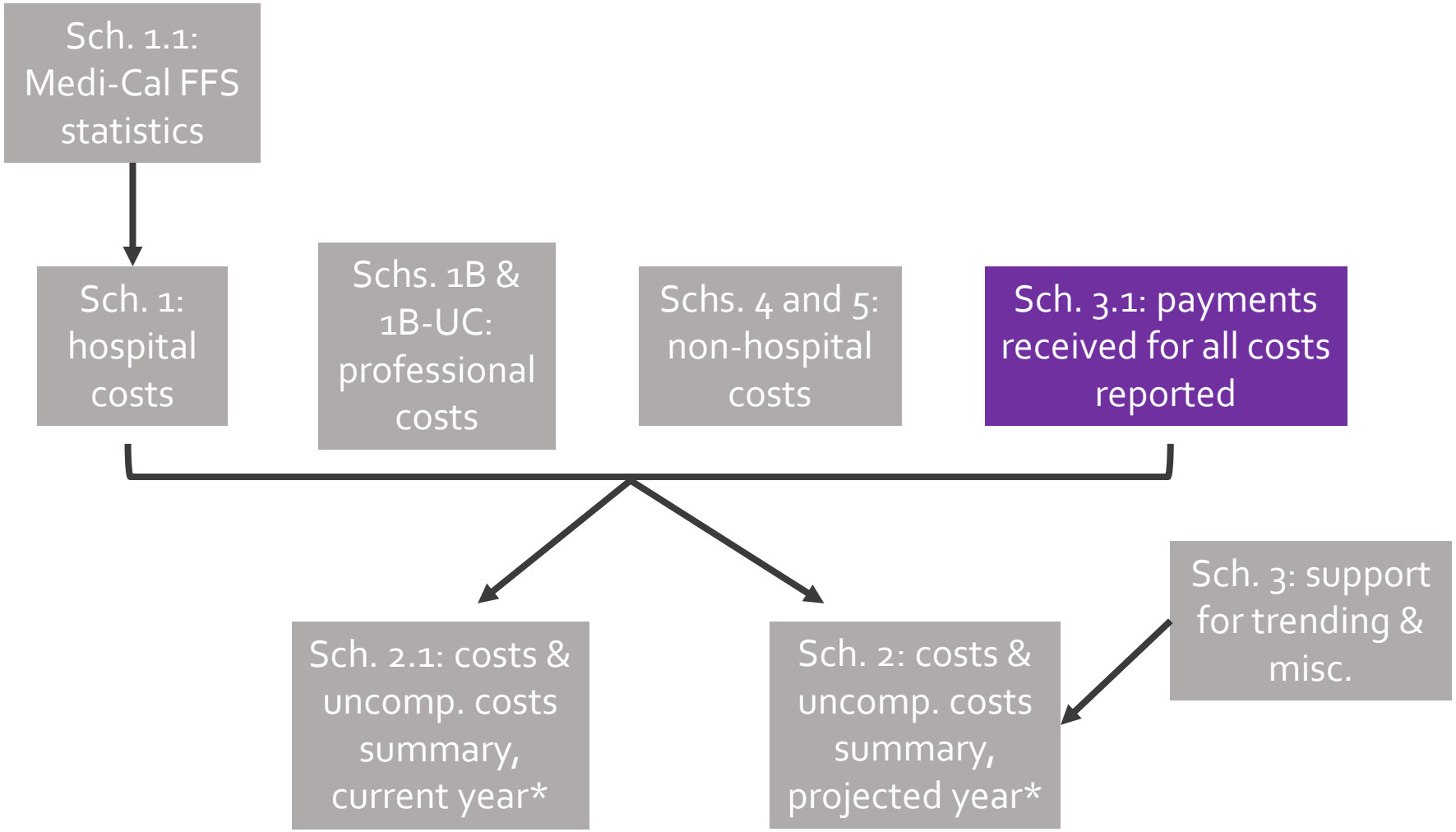

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Schedule 4: non-hospital costs (uninsured only)

1. Cost/visit (non-hospital clinic cost report)
2. Mental health costs (from Sch. 5)
3. Direct reporting (anything below), for contracted or other misc. costs

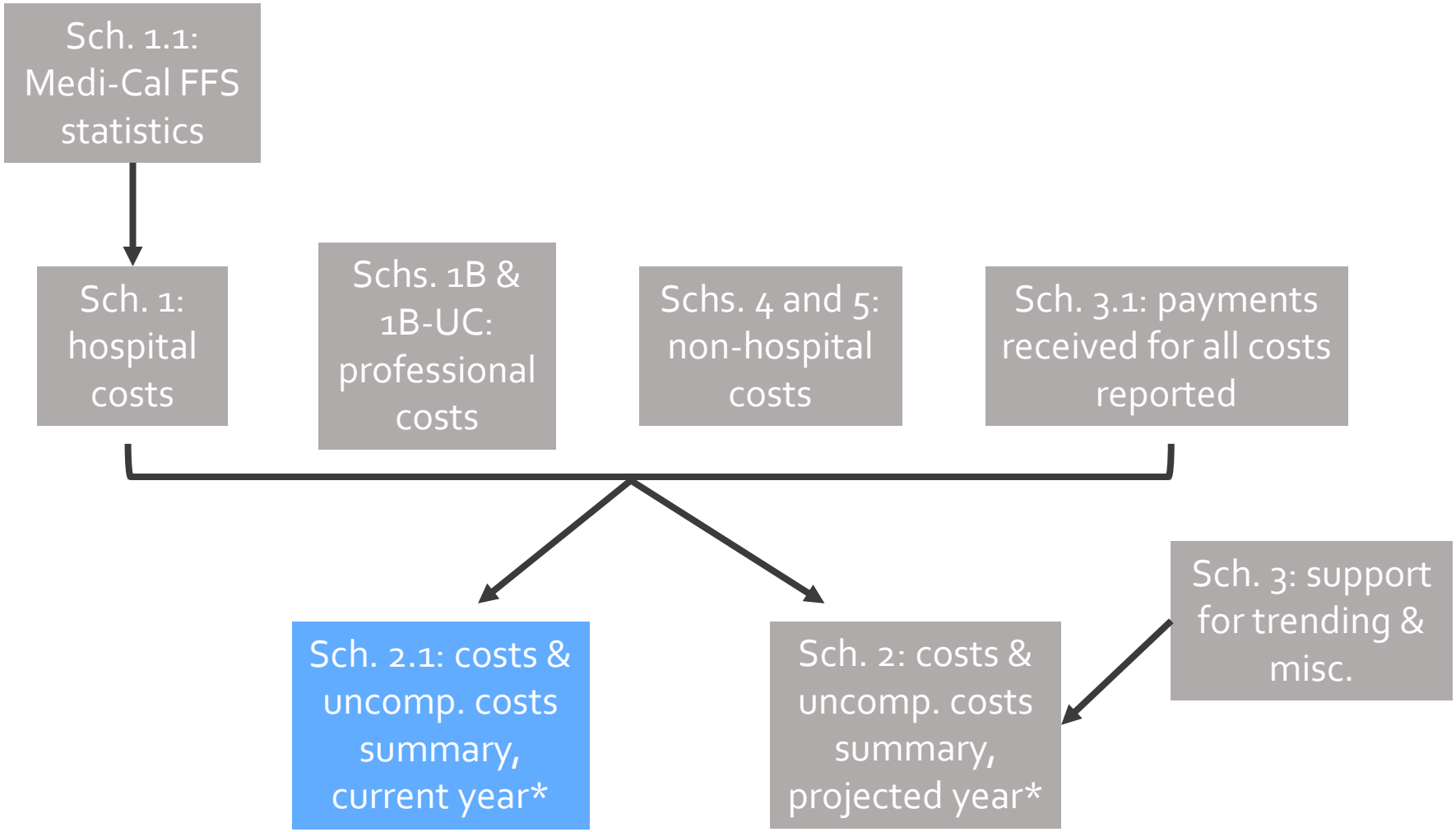
Non-Hospital and Contracted Hospital Costs Related to the Uninsured		Costs on DPH's Books 7/1/18-6/30/19		Costs on County Books 7/1/18-6/30/19	
Location of non-hospital services.	COST Per Visit (from non-hospital clinic cost report)	Uninsured Visits (from provider records)	Cost of Service Provided to the Uninsured	Uninsured Visits (from provider records)	Cost of Service Provided to the Uninsured
County FQHC clinics	537.64	19,141	10,290,987		-
County OP Clinics (non-FQHC)			-		-
Public Health Clinics			-		-
			-		-
			-		-
Subtotal Non-Hospital Clinic Costs			10,290,987		-
Mental Health Clinic Costs (From Sch.5)					4,666,078
Alcohol and Drug Costs (From Sch.5)					7,165,126
Mental Health Purchased Service (From Sch.5)					6,020,224
Subtotal Mental Health and Substance Abuse Costs					17,851,427
Other medical purchased services (list service type)					
Trauma Services at non-county hospitals					
Emergency Services at non-county hospitals					731,538
Physician Trauma and Emergency Services					
Healthcare Care Clinic Services for GPP PCAP (uninsured patients)		CHC*	9,862,011		
Services not provided at County hospitals					
Hospital Services Purchased by DPH Hospital for Uninsured Patients					
Payments to Physicians under contracts where payment is solely for services to uninsured hospital inpatient and outpatient clinic patients.					
Drugs and Supplies to uninsured patients outside the hospital setting					
APD COSTS (OUTSIDE COSTS)			693,503		

Schedule 3.1: Payments

- Listing various payments, across different cost types
- Important for Schedule 2.1

	Medi-Cal		Medi-Cal FFS			
1			Pre ACA Eligible	New Eligibles 94% FMAP	New Eligibles 93% FMAP	Total
2			7/1/18-6/30/19	7/1/18-12/31/18	1/1/19-6/30/19	
3	Estimated Admin. Day Payments for Cost Report Year		388,975	440,353	562,910	1,392,238
4	Estimated Blood Factor Payments for Cost Report Year		-	-	-	-
5	Estimated Medi-Cal Payments for Dual Eligible Claims included in Medi-Cal calculation		80,248			80,248
6	Medicare **Base** Payments for Dual Eligible Claims Included in Medi-Cal calculation.		5,336,893			5,336,893
7	Medicare **Supplemental** Payments for Dual Eligible Claims Included in Medi-Cal calculation. **(GME, IME, Medicare DSH, etc.).**		269,151			269,151
8	Patient Share of Cost Obligation for Dual Eligible Claims included in Medi-Cal calculation.		91,337			91,337
9	Other Estimated Payments for Cost Report Year		234,169	14,051	-	248,220
10			To Schedule 3 Step 3	To Schedule 3 Step 3	To Schedule 3 Step 3	
11	Medi-Cal Share of Cost Charges (Established Medi-Cal)		33,513	-	-	33,513
12	Medi-Cal Share of Cost Payments Received (Established Medi-Cal)		-	-	-	-
13			To Schedule 2.1 Step 1	To Schedule 2.1 Step 1	To Schedule 2.1 Step 1	
14	Medicare/Medi-Cal Dual Eligible for Unreimbursed Cost Calculation (Only Payments Not Reported Above)					
15	**Base** Payments Received from Medicare for Dual Eligible inpatient claims not included in the Medi-Cal cost calculation.		6,374,094			6,374,094
	Supplemental Payments Received from Medicare for Dual Eligible inpatient claims not included in the Medi-					

Structure of P14 schedules (tabs)



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Schedule 2.1: FFS IP

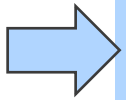
- Step 1: Calculating Medi-Cal FFS IP reimbursement

	1a	1b	1c	1d
PLEASE FILL IN THE PURP[LE HIGHLIGHTED CELLS	Pre ACA Eligible Medi-Cal FFS	(July - December) (New Eligibles 94% FMAP	(January to June) (New Eligibles 93% FMAP	Total Medi-Cal and Physician SPA Costs
STEP 1: Calculate Medical Costs for Fiscal Year Adjusted for State Only Medi-Cal Costs and Medi-Cal Share of Costs				
Total IP Hospital Cost Per Day (from Schedule 1)	$ 3,913	$ 3,646	$ 3,687	
Less Other Payments per Day (from Schedule 3)	310	89	197	
Net IP Hospital Cost per Day	3,603	3,557	3,490	
Medi-Cal days for Fiscal Year (from Schedule 1)	10,980	3,855	3,069	
Net Medi-Cal costs for Fiscal Year	39,561,570	13,713,440	10,711,922	63,986,932
Percentage Reduction for State Only Medi-Cal Claims (from Paid Claims data) (From Schedule 3)	1.17%	1.17%	1.17%	1.17%
State Only Medi-Cal Estimated Costs	(462,870)	(160,447)	(125,329)	(748,647)
Less Medi-Cal Share of Cost Charges (From Schedule 3.1)	-	-	-	-
Net Medi-Cal Cost reduced by State Only and Medi-Cal Share of Cost Charges	$ 39,098,700	$ 13,552,993	$ 10,586,592	$ 63,238,285
Medi-Cal Share of Costs Charges	$ -	$ -	$ -	$ -
Less Medi-Cal Share of Cost Payments (From Schedule 3.1)	-	-	-	-
Unreimbursed Uninsured Cost for Share of Cost Patients (Information)	$ -	$ -	$ -	$ -
FMAP	50.00%	94.00%	93.00%	

Schedule 2.1: Steps to sum it all up!

Step	Description	Flows from
Step 1	Medi-Cal FFS IP	Sch. 1, Sch. 3, Sch. 3.1
Step 2	Medi-Cal Shortfalls (non-FFS)	Sch. 1, Sch. 3.1
Step 3	Uninsured Hospital Costs (DSH)	Sch. 1, Sch. 3.1
Step 4 (County only)	Uninsured Professional Costs	Sch. 1B
Step 5 (County only)	Uninsured Non-Hospital Costs	Sch. 4
Step 6 (UC Step 4)	PNPP (Physician SPA)	Sch. 1B/1B-UC, Sch. 3.1

FFS IP Cost-Based Reimbursement



Step 7 (UC Step 5) Hospital Uncompensated Costs and Total Uncompensated Costs

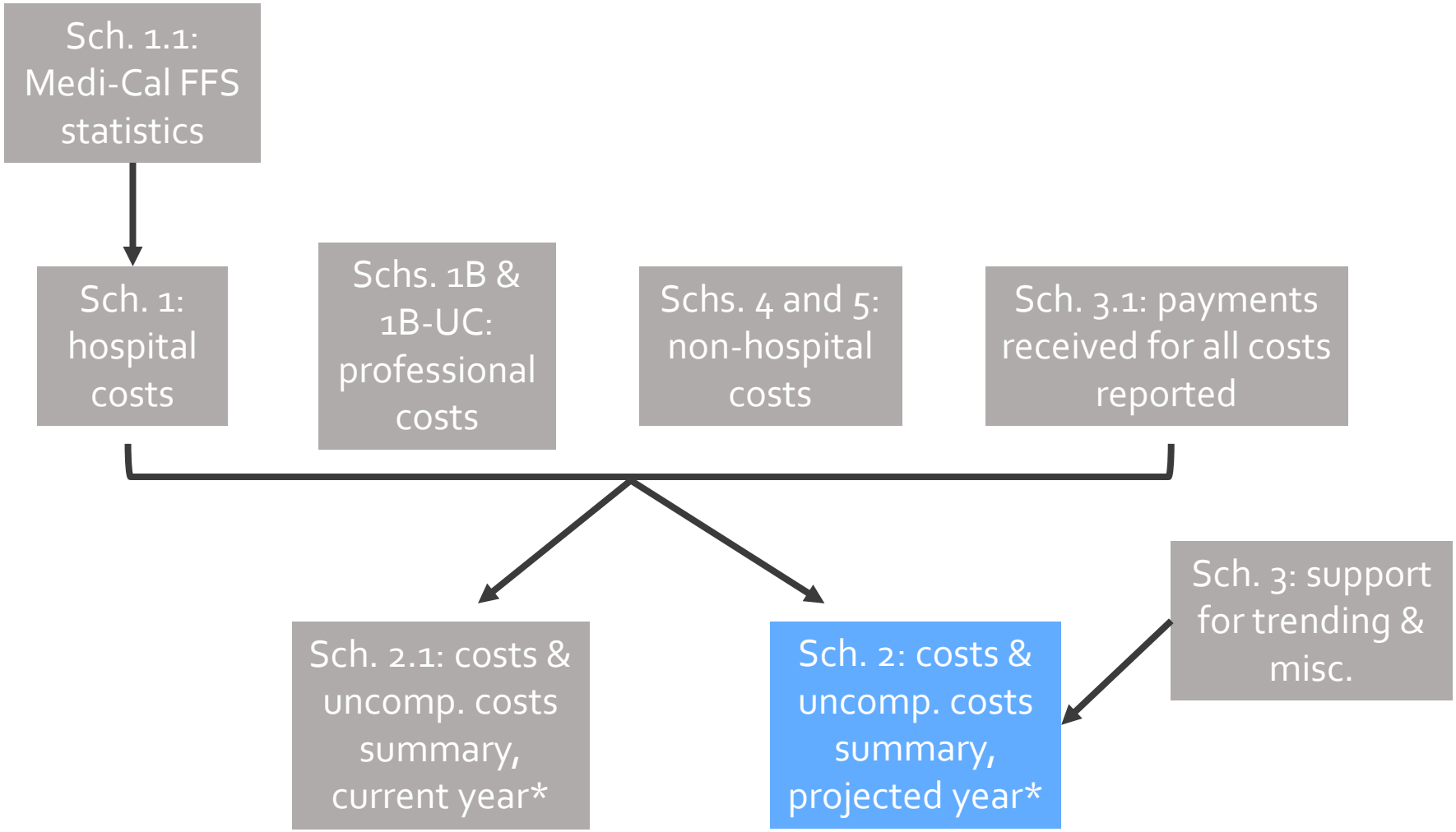
PNPP Cost-Based Reimbursement

Schedule 2.1: Totals

- Step 7 sums results of all previous steps (except FFS IP and Physician SPA) (step 5 on UC P14)
- Arrives at totals of Uncompensated Care Costs across steps
  - Hospital UCC equivalent to UC DSH CPEs
  - Uninsured UCC important for potential GPP evaluations

name:	ARMC - P14 FY1819 V1 Initial 052220.xlsx			
		8	9	10
		Hospital UCC (DSH CPEs)	Uninsured UCC	Total Reported UCC
	PLEASE FILL IN THE PURP[LE HIGHLIGHTED CELLS			
STEP 7 Summary of Hospital Uncompensated Care Costs and Total Uncompensated Care Costs		$ 11,602,026	$ 31,818,131	$ 32,865,886
	Check Total for Medi-Cal Cost Calculation			

Structure of P14 schedules (tabs)



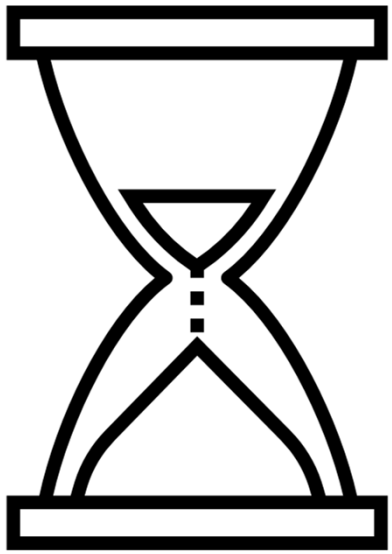
*in older years, continued to 2.1-A and 2-A respectively

Schedule 2: project it to next year!

- Using all the same steps as Sch. 2.1, projecting to next year

PLEASE FILL IN THE PURPLE HIGHLIGHTED CELLS	4a1	4a2	4b
	Dual Eligible Pre-ACA Medi-Cal Managed Care	Non-Dual Pre-ACA Eligible Medi-Cal Managed Care	Medi-Cal Managed Care New Eligibles
Inpatient hospital costs per day (excluding physician costs) (from Sch. 1)	$ 6,244	$ 5,488	$ 5,711
Estimated **Inpatient** days for Projected year.	15,236	10,771	5,068
Total Projected **Inpatient** Hospital Costs for Projected year.	95,129,611	59,107,842	28,948,482
Outpatient Hospital Costs Per Visit (excluding physician costs) (from Sch. 1)	$ 1,302	$ 1,053	$ 1,277
Estimated **Outpatient** visits for Projected year **(count by same methodology as used for Schedule 1, row B)**.	32,459	15,402	5,470
Total Projected **Outpatient** hospital costs for Projected Year	42,274,310	16,215,446	6,986,993
Estimated **total projected** hospital costs for Projected year.	137,403,921	75,323,288	35,935,475
Cost Trend Factor (from Schedule 3).	1.027	1.027	1.027
Estimated **total projected** trended hospital costs for Projected year.	141,142,785	77,372,891	36,913,306
Total payments including gross supplemental (excluding physician portion) payments. (From Schedule 3.1)	(106,077,125)	(82,092,682)	(38,834,332)
Projected Medicaid Shortfall (Longfall)	$ 35,065,660	$ (4,719,791)	$ (1,921,026)

Break!



We'll start again…

The many mappings

Mapping payer type to P14 payer column

Payer type in system (illustrative only)	P14 payer, mapped
Alameda Alliance Medi-Cal	Medi-Cal Managed Care
Anthem Medi-Cal	Medi-Cal Managed Care
Medi-Cal	Medi-Cal FFS
Medi-Cal Restricted	Medi-Cal FFS or Uninsured
County Mental Health	Medi-Cal Psych or Uninsured
County Medical Indigent	Uninsured
Ability to Pay Program	Uninsured
Self-Pay	Uninsured

Counties will be doing similar mappings to determine what services generate GPP points – are these mappings consistent?

Mapping denial codes to claimability

Denial code	Potential P14 category
Lack of medical necessity	Unclaimable
Claim submitted past cutoff date	"Other Medi-Cal"
Patient ineligible for Medi-Cal on service date	Potentially uninsured (check other patient info)
Medi-Cal does not cover given service (Restricted/Emergency Medi-Cal)	**Uninsured**
Patient must pay share of cost	Medi-Cal FFS (share-of-cost portion is deducted later)

Mapping from service to major cost-category

- Categories you need to determine for cost reporting and other reporting:
  - Is the service hospital-based?
  - Is it an FQHC service?
  - Is it a professionally-billed service (physician or other)?
- How might a system make this categorization? Not always prescribed, but auditors will ask!
- Possibilities for mapping:
  - CPT codes
  - Modifiers
  - Revenue codes
  - Place of service
  - Other?

P14 to payment flow

Schedule 2, step 1: interim FFS rates

PLEASE FILL IN THE PURPLE HIGHLIGHTED CELLS	1	1a	1b	1c	
	Medi-Cal FFS, Physician SPA Projected Costs				
	7/1/19-6/30/20 Pre ACA Eligible	New Eligibles 93% FMAP 7/1/19-12/31/19	New Eligibles 90% FMAP 1/1/20-6/30/20	Total	
STEP 1: Calculate Adjusted Medi-Cal IP Cost/Day (Medi-Cal Interim Rate)	Interim Rate Calculation				
Total IP Hospital Cost Per Day(From Schedule 1)	$ 3,913	$ 3,646	$ 3,687		
Less Other Payments per Day (from Schedule 3)	(310)	(89)	(197)		
Net IP Hospital Cost per Day	3,603	3,557	3,490		
Cost Trend Factor (from Schedule 3)	1.051	1.051	1.051		
Calculated Cost per Day trended to current year (Trended Cost per Day)	3,788	3,740	3,669		
Estimated Medi-Cal days for Projected year	10,981	2,699	2,148	15,828	
Estimated Medi-Cal costs for Projected year	41,591,017	10,091,200	7,882,496	59,564,712	
Percentage Reduction for State Only Medi-Cal Claims (from Paid Claims data)(From Schedule 3)	1.17%	1.17%	1.17%	1.17%	
State Only Medi-Cal Estimated Costs	(486,615)	(118,067)	(92,225)	(696,907)	
Less Medi-Cal Share of Cost Charges (Patients SOC Obligation)	-	-	-	-	
Net Medi-Cal Cost reduced by State Only and Medi-Cal Share of Cost Charges	$ 41,104,402	$ 9,973,133	$ 7,790,271	$ 58,867,805	
Medi-Cal Share of Costs Charges (From Line 21)	$ -	$ -	$ -	$ -	
Less Medi-Cal Share of Cost Payments (From Schedule 3.1)	-	-	-	-	
Unreimbursed Uninsured Cost for Share of Cost Patients (Information)	$ -	$ -	$ -	$ -	
Cost Per Day for Interim Payment Calculation (Total Projected Cost/Total Projected Days) (F18/F17)	$ 3,763	$ 3,763	$ 3,763		
FMAP	50.00%	93.00%	90.00%		
Estimated Medi-Cal Interim Rate = Cost per Day for Interim Payment Calculation times FMAP (Line 28*29)	$ 1,882	$ 3,500	$ 3,387		

Interim FFS rates: 2 yrs' trending

Sch. 2.1:

Claimable cost/day, FY19-20

after other payments (Medicare, etc.)

Sch. 2: (with trend from Sch. 3):

Projected cost/day, FY20-21

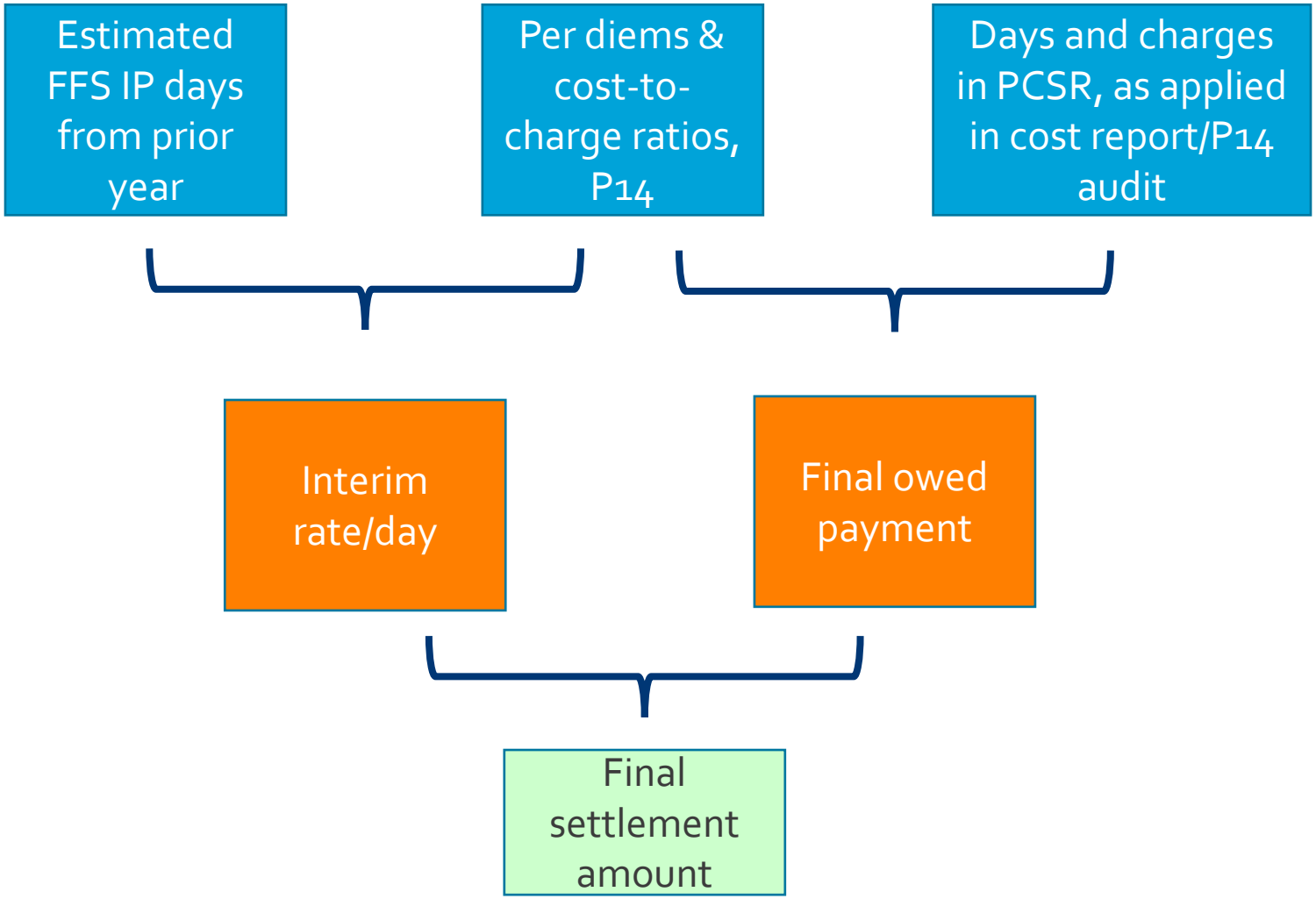
Hospital-CPI + other trend factors

DHCS calculations (outside P14):

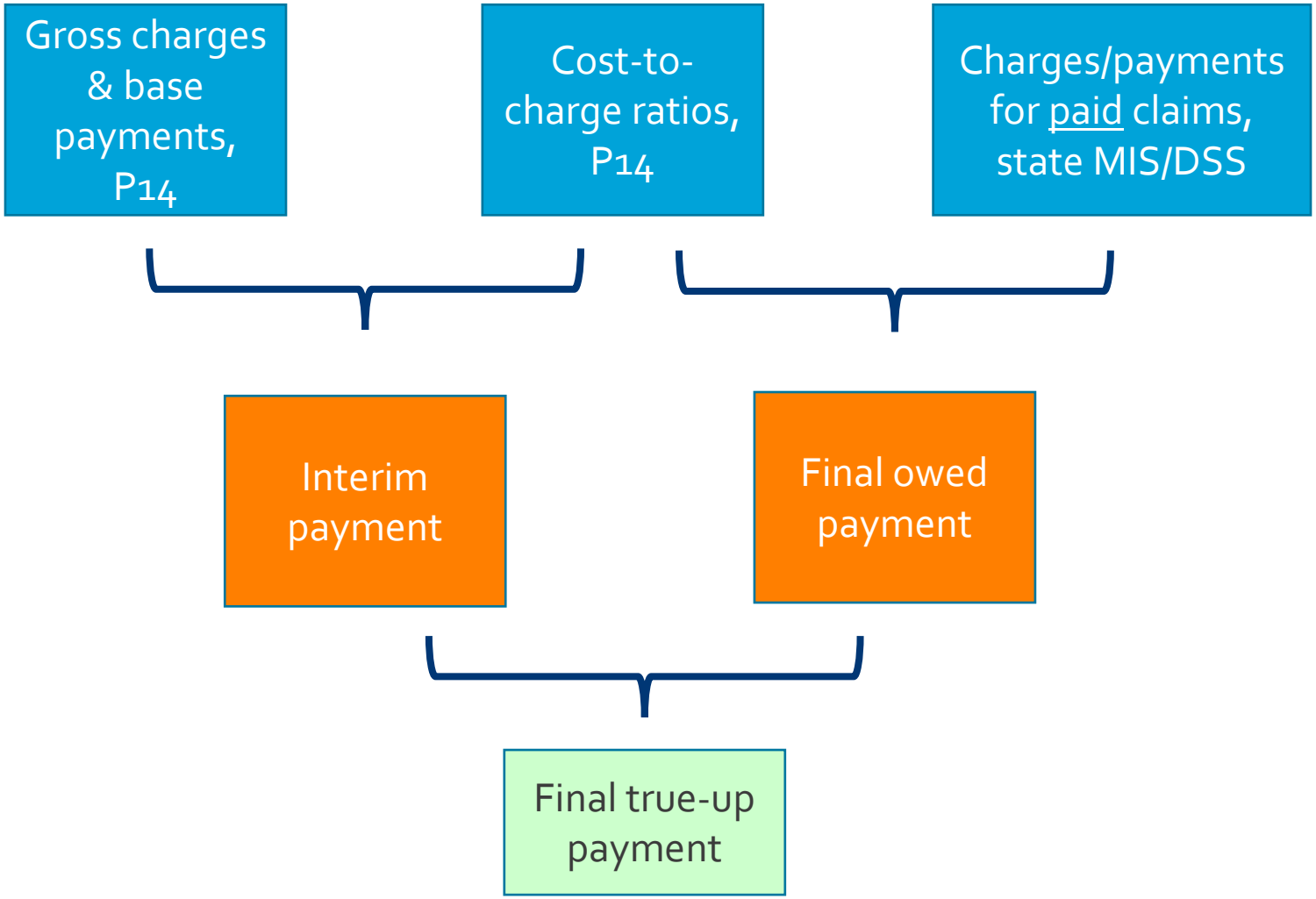
Interim rate Medi-Cal will pay during FY21-22

Hospital CPI (COVID)

FFS IP true-up process



AB915 or PNPP process



Uninsured costs, DSH CPEs, & discharges

- Uninsured costs: for GPP evaluation only (counties)
- Currently DSH CPEs & discharges for UCs only; could become applicable to counties again!

Schedule 2 (Projected)

PLEASE FILL IN THE PURPLE HIGHLIGHTE	8	9
	Uninsured	DSH CPEs
STEP 5: Summary of Projected Allowable Hospital DSH CPEs	$ 22,871,457	$ 30,847,024

Schedule 3

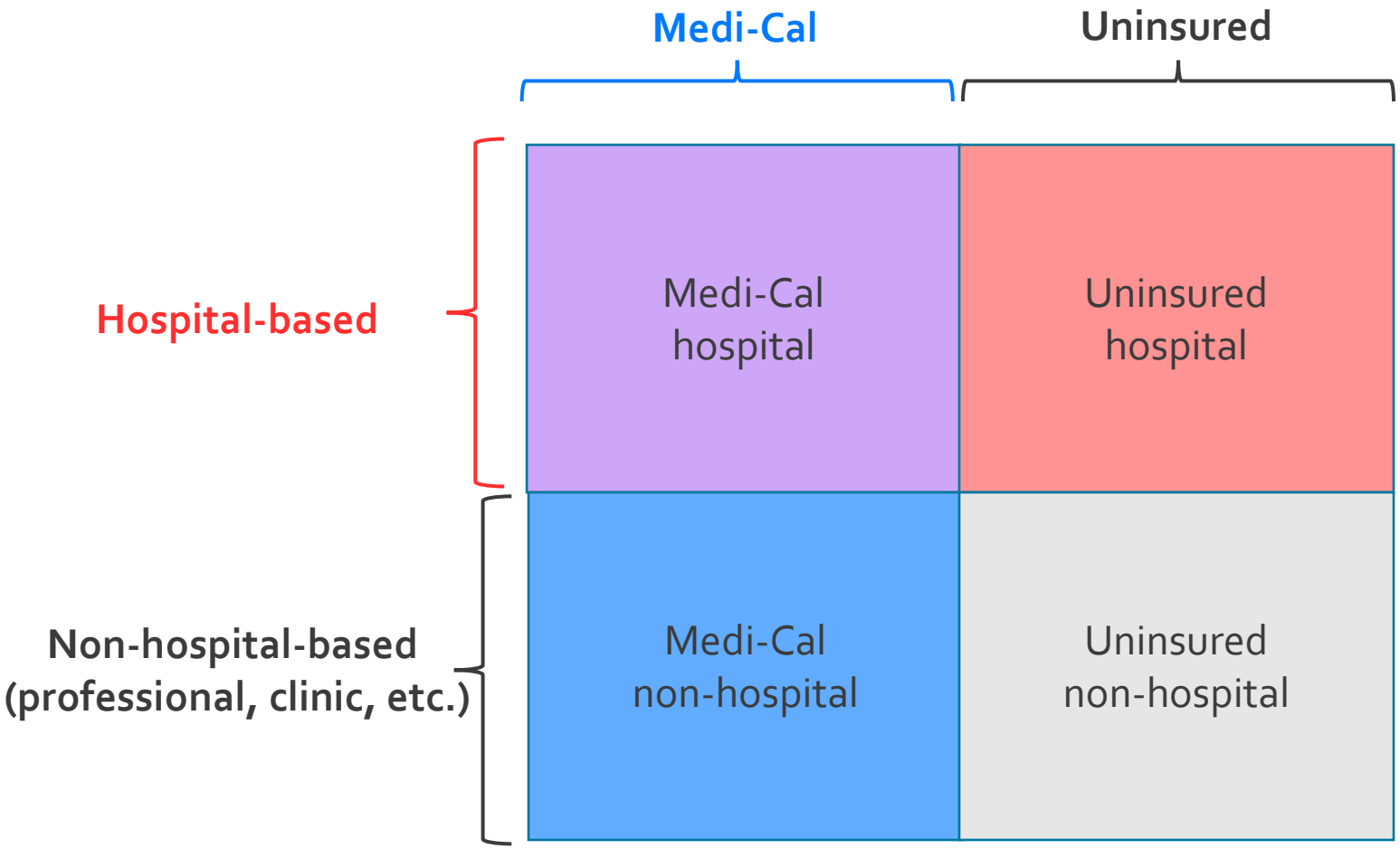
Discharges		Unit
		All acute discharges, general acute and Subprovider.
Payer	Medi-Cal FFS	
	...Full dual eligibles in Medi-Cal FFS	278
	...All others in Medi-Cal FFS (including Medi-Cal Psych)	2,739
	...Total	3,017
	Medi-Cal MC	2,267
	Medicaid Out-Of-State	0
	Uninsured	950

Sums for waiver model	Sum
Medi-Cal	5,006
Uninsured	950

Reporting Medi-Cal managed care revenues in P14

- Rate-range
- EPP
- QIP
- GME
- HQAF

Schedules/claimability recap:
Which of these kinds of costs are reported in the P14s?



Payment timing

Payment stream	Interim payment timing	Final payment / final reconciliation timing
FFS IP	Interim rates updated every July 1 from latest P14 (due May 31)	Approx. 2 years after FYE (update after all audits)
AB915	Feb-Mar of each year (AB915 claim form)	TBD
PNPP	Apr-Jun of each year (P14 projected UCC)	TBD
UC DSH	Quarterly from P14 projected data	Approx. 3.5 years after FYE (after all audits inc. Myers)
HQAF direct grant (distributed by CAPH Board consensus)	Quarterly payments use P14 current data most recently available	Not reconciled, only adjusted going forward
AB85	~May before year starts, from AB85 projections	2 years after FYE, unless appealed

Takeaway and next steps

Takeaways

- A wide array of financial and administrative data comes together to result in claimable costs/CPEs for reimbursement purposes
- Some of this can fall into autopilot and it should periodically be rechecked for validity and interaction problems
- The bucketing of payers for P14 columns is a complex exercise incorporating logical and legal steps
- Look to key outputs like gross claimable costs and cost/day to understand any swings and to be comfortable legally attesting to your reports