MEDICAL CENTERS: MEDI-CAL SUPPLEMENTAL PAYMENTS

Contents

MEDICAL CENTERS: MEDI-CAL SUPPLEMENTAL PAYMENTS

I. INTRODUCTION

This chapter describes the Medi-Cal (Medicaid) supplemental payment programs, as well as how to budget, account for, and report these funds. The following Medi-Cal supplemental payment programs are discussed:

SB 855 - Medi-Cal Disproportionate Share Hospitals Payment Program

SB 1255 - Medi-Cal Emergency Services and Supplemental Payments Program

Med Ed Program - Medi-Cal Medical Education Payment Program

SB 1732 - Medi-Cal Construction and Renovation Reimbursement Program

The SB 855, SB 1255 and SB 1732 programs provide supplemental Medi-Cal payments to disproportionate share hospitals, which are hospitals that treat a high number of Medi-Cal and low income patients. The Medical Education Payment Program provides supplemental Medi-Cal payments from two funds (Fund A and Fund B) to certain hospitals in recognition of medical education costs associated with healthcare services rendered to Medi-Cal beneficiaries. Hospitals receiving funds from the Medical Education Program Fund A are not required to be disproportionate share providers, while those receiving funds from the program's Fund B are required to be disproportionate share hospitals.

II. SUPPLEMENTAL PAYMENT PROGRAM

A. SB 855, MEDI-CAL DISPROPORTIONATE SHARE HOSPITALS PAYMENT PROGRAM

1. Definition

SB 855 - Disproportionate Share Hospitals (DSH) Payment Program provides supplemental Medi-Cal payment adjustments to acute care hospitals that treat a high volume of low-income and Medi-Cal patients for inpatient care. The program uses formulas to determine hospital eligibility, the amount of funding (non-federal and federal) for the program, and the distribution of program funds to eligible hospitals. The DSH program receives mandatory transfers from public entities (i.e., counties, hospital districts, and the University of California) that are matched by federal Medicaid funds. A formula is used to determine the amount of funds to be distributed to eligible hospitals.

2. Eligibility

An eligible hospital must have either: 1) a Medicaid inpatient utilization rate (based on days) of one standard deviation above the statewide mean Medicaid inpatient rate; or 2) a Medicaid inpatient utilization rate of one percent, with a low income utilization rate in excess of 25 percent. The California Department of Health Services determines eligibility by using hospital data reported on the Office of Statewide Health Planning and Development's "Annual Hospital Disclosure Report." Based on the calculation by the Department of Health Services, a DSH list is published with the names of hospitals eligible for SB 855 funding. In addition, the federal Medicaid program requires most DSH hospitals to have at least two obstetricians with staff privileges who have agreed to provide obstetric services to Medi-Cal patients. A DSH hospital must file a completed Obstetrician Availability Certification annually.

II. SUPPLEMENTAL PAYMENT PROGRAM (Cont.)
A. SB 855, MEDI-CAL DISPROPORTIONATE SHARE HOSPITALS PAYMENT PROGRAM (Cont.)

3. Funding

The DSH program is funded from non-federal and matching federal sources. Public entities that hold the licenses of eligible DSH hospitals provide non-federal funding through mandatory intergovernmental transfers (IGT) to the Medi-Cal Inpatient Adjustment Fund, which is administered by the Department of Health Services. The IGTs, less a state administrative fee, are matched by federal Medicaid funds, approximately dollar for dollar. The size of the federal match changes annually. The amount of IGT by public entity is based on the ratio of individual public hospitals' projected DSH payments to that of all public hospitals and it is increased by their entity's pro rata obligation for all private hospitals' DSH payments.

Federal cost caps established under the Omnibus Budget Reconciliation Act of 1993 (OBRA'93) limit both the overall program size in each state and the amount of funding by individual hospital. All public DSH hospitals are capped at 175% of unreimbursed costs, whereas private DSH hospitals are capped at 100% of unreimbursed costs.

Medi-Cal paid days and revenues attributable to Medi-Cal prepaid health plan members that have been treated by a hospital are included in the calculation used to determine a hospital's total DSH funding for the payment year.

Inclusion on the DSH list does not necessarily guarantee that a hospital will receive DSH funds. Provisions of the OBRA'93 limit individual hospital DSH payment adjustments to a percentage of a hospital's uncompensated care costs. As a result, this limit may reduce, or eliminate altogether, a hospital's otherwise projected maximum DSH payment adjustment amount.

If all SB 855 funds are not expended in the "base program," the Department of Health Services provides for a Secondary Supplemental Lump-Sum

Payment Program in order to expend all SB 855 funds within the fiscal year.

4. Distribution

DSH funds are divided into three separate hospital pools: public, private, and those converted from public to private. The formula for calculating DSH payments considers the number of inpatient days of both Medi-Cal and uncompensated care, more heavily rewarding Medi-Cal care. Distributions for the "base program" are based on 80% of the prior calendar year's Medi-Cal paid days multiplied by a per diem amount. The per diem amount increases as the hospital's percentage of low-income patients increases. Annual amendments provide for "Secondary Supplemental Lump-Sum Payments," which are distributed on a pro rata basis from remaining federal funds to hospitals that have not exhausted their individual cost caps.

SB 855 payments are included with the normal periodic Medi-Cal per diem payments. The Medi-Cal per diem payments are negotiated with the California Medical Assistance Commission (CMAC) under the Selective Provider Contracting Program. By law, the negotiated per diem payments are confidential.

5. Process

At the beginning of the fiscal year, the California Department of Health Services, using data from the Office of Statewide Health Planning and Development's "Annual Hospital Disclosure Report" prepared two years previously, determines which public and private hospitals qualify to be included on the DSH list. The hospitals are notified of their eligibility when the DSH list

II. SUPPLEMENTAL PAYMENT PROGRAM (Cont.)
A. SB 855, MEDI-CAL DISPROPORTIONATE SHARE HOSPITALS PAYMENT PROGRAM (Cont.)
5. Process (Cont.)

is published. Since part of the data used in the DSH payment calculations comes from the Medi-Cal Managed Care Health Plans, the Department of Health Services requests that hospitals verify the accuracy of the Medi-Cal Managed Care Health Plans data.

Following the verification of data, the Department of Health Services calculates the amount of IGT and DSH payment adjustments for each eligible hospital. The Department sends each hospital a letter indicating the total IGT amount for the "base year" program. The Department sends a letter to the public entities with an attached invoice requesting that a transfer of funds be made to the Department of Health Services, which is deposited into the Medi-Cal Inpatient Payment Adjustment Fund. After receiving the IGT payments from the public entities, the Department of Health Services submits a claim to the Centers for Medicare and Medicaid Services (CMS) for federal matching funds. Department of Health Services supplemental payments are made to eligible DSH hospitals as an addition to the hospital's negotiated per diem payment, usually every two weeks. After reimbursing the Office of the President for the funds advanced through the intergovernmental transfer, the medical centers that are disproportionate share providers retain the remainder of the SB 855 payment.

The University responds to the Department of Health Services invoice by preparing a Domestic Electronic Funds Transfer Request and submitting it to the Office of the Treasurer after receiving the appropriate approvals. The funds are transferred from the Commercial Paper program to the Department of Health Services on the date requested. The Department sends a receipt to the

Office of the President acknowledging the University's IGT.

Upon receipt of a SB 855 payment, the medical center notifies the Office of Hospital Accounting of the date and amount received. The Office of Hospital Accounting prepares the necessary journals to recover the amount of funds needed to repay the Commercial Paper program for funds transferred on behalf of an eligible medical center, as well as to assess interest for the transferred funds. The interest charge is calculated at the Commercial Paper rate from the date of transfer to the date the funds are recovered by the Office of the President, usually on the same date that the funds are received by the medical center. The eligible medical center keeps the amount of SB 855 funds that are in excess of the total IGT to be made on its behalf by the Office of the President in the payment year (the medical center's "net benefit"). The amount of SB 855 funds received by the eligible medical center that is less than the IGT is recovered by the Office of the President to repay the Commercial Paper Program.

6. Budget

The Department of Health Services provides the Office of the President with the amount of the IGT, the total SB 855 payment, and net benefit for each eligible medical center, which is then shared with all eligible medical centers. The medical centers record the full amount of the estimated net benefit when preparing their full year budget and full year projections. The medical centers record 1/12th of the full year budgeted amount of the net benefit of SB 855 funds in their monthly financial reports. Because eligibility is known at the beginning of the fiscal year, eligible medical centers have an irrevocable right to these funds; therefore, the medical centers can budget and accrue these funds effective July 1.

II. SUPPLEMENTAL PAYMENT PROGRAM (Cont.)

A. SB 855, MEDI-CAL DISPROPORTIONATE SHARE HOSPITALS PAYMENT PROGRAM (Cont.)

7. Accounting And Reporting

a. Office of the President

Since the mandatory IGTs are not made directly by a medical center, the transfer is not recorded in the medical center's books and records. The amount of funds transferred is recorded by the Office of the President as a receivable (i.e., SB 855 Receivable J-112090).

b. Recovery of Transferred Funds and Interest Charged on those Funds by the Office of the President

The Office of the President prepares the necessary journals to recover the funds transferred to the Department of Health Services on behalf of those medical centers eligible to participate in the SB 855 program. The transferred funds are recovered following the receipt of funds by the medical centers from the Department of Health Services.

The Office of the President entries for the recovery of the transferred funds are:

Dr. Campus Financial Control
J-1195XX-0900XX-0
Cr. Current Fund CP Liability
J-101691-001729-0

Dr. CP Liability Control
M-115664
Cr. SB 855 CP Receivable
M-112090

The Office of the President entries for the interest charged on the transferred funds are:

Dr. Campus Financial Control
J-1195XX-0900XX
Cr. Commercial Paper
J-101729-001729-0-2274

c. Medical Centers

Because disproportionate share payments may be delayed and because funding in the current year is based on a formula using historical data rather than services actually rendered during the year payments are made, the medical center accrues 1/12 of the estimated net benefit, thereby equalizing the payment throughout the fiscal year. As soon as the actual amount is known, the medical center adjusts its year-to-date accrual amount for any difference between the estimated and the actual amount to be received. The medical center adjusts its monthly accrual for the remainder of the fiscal year.

The hospital records 1/12 of the net benefit as follows:

Dr. Other Receivables

Cr. Contractual Allowances - Medi-Cal

1) To record cash payment of SB 855 Funds:

Dr. Cash
Cr. Other Receivables - (Total SB 855 Payment)

2) Reversing entry on the medical center's books before recovery of funds transferred by OP:

II. SUPPLEMENTAL PAYMENT PROGRAM (Cont.)
A. SB 855, MEDI-CAL DISPROPORTIONATE SHARE HOSPITALS PAYMENT PROGRAM (Cont.)
7. Accounting And Reporting (Cont.)
c. Medical Centers (Cont.)

Dr. Other Receivables
Cr. Cash due to Financial Control (Report as "Contra Cash on the medical center's Balance Sheet)[1]

3) Journal entry when the transferred amount is recovered by OP:

Dr. Other Receivables - (for amount transferred by OP)
Cr. Financial Control

d. Secondary Supplemental Payment Adjustment

A Secondary Supplemental Lump-Sum Payment Adjustment is available when federal matching funds remain under the state's total cap, after all the initial DSH payments have been accounted for. These funds are available to hospitals that meet the statutory eligibility requirements at the close of the SB 855 payment year, June 30.

The statutory eligibility requirements are: (1) that hospitals remain in operation for the entire period, i.e., October 1 through June 30, and (2) that hospitals have received or earned payment adjustments relating to the current payment adjustment year an amount that is less than the hospital's OBRA '93 cap limitation for the current payment adjustment year.

The fiscal year in which the eligible medical centers record the estimated amount is determined by the date on which the Department of Health Services announces that a Secondary Supplemental

[1] The reversing entry is made so that the only "net benefit" is recorded on the hospital's financial statement.

Lump-Sum Payment shall be made. If the Department announces the payment prior to the close of the medical center's books for the fiscal year, the estimated amount provided by the Office of the President is recorded for that fiscal year; otherwise, the estimated amount is recorded in the next fiscal year.

The IGT, DHS payment and recovery of transferred funds by the Office of the President will be the same as under the SB 855 "base program."

As soon as the exact amount of the Secondary Supplemental Lump-Sum Payment Adjustment is known, the medical centers adjust their entry from estimated to actual.

B. SB 1255, MEDI-CAL EMERGENCY SERVICES AND SUPPLEMENTAL PAYMENTS PROGRAM

1. Definition

SB 1255 - The Emergency Services and Supplemental Payments Fund provides supplemental Medi-Cal payments to disproportionate share hospitals, which are hospitals that treat a high number of Medi-Cal and low-income patients. The program receives voluntary transfers from public entities, which are matched by federal Medicaid funds, for distribution to eligible hospitals after negotiations with the Executive Director of CMAC. Negotiations with CMAC determine the amount of SB 1255 funds to be received by eligible hospitals, as well as the size of the voluntary transfer. Negotiations with CMAC usually require that eligible hospitals agree to provide specified services to the Medi-Cal patient population. By law, rates negotiated with CMAC are confidential; therefore, SB 1255 negotiations are confidential.

2. Eligibility

A hospital eligible for SB 1255 funds must be:

II. SUPPLEMENTAL PAYMENT PROGRAM (Cont.)

B. SB 1255, MEDI-CAL EMERGENCY SERVICES AND SUPPLEMENTAL PAYMENTS PROGRAM (Cont.)

2. Eligibility (Cont.)

1) A Medi-Cal Selective Provider Contracting Program hospital;

2) A disproportionate share provider, based on requirements specified in state statute and the California State Medi-Cal Plan; and

3) A licensed provider of basic or comprehensive emergency medical services (or a children's hospital that provides such emergency services in conjunction with another licensed hospital), or meet other requirements as specified by state statute.

3. Funding

The Emergency Services and Supplemental Payments Fund is funded from non-federal and federal sources. Public entities (i.e., counties, hospital districts, and the University of California) that hold the licenses of eligible DSH hospitals provide non-federal funds. These public entities make voluntary transfers by way of IGTs to the Department of Health Services, Emergency Services and Supplemental Payments Fund. The IGTs are matched by federal Medicaid funds, approximately dollar for dollar; the size of the federal match changes annually. The amount of funding available to eligible hospitals is limited by the overall program size (the negotiated IGT and the matching federal funds).

4. Distribution

As this is a voluntary program, the amount of funds to be distributed is determined by the amount deposited in the Emergency Services and Supplemental Payments Fund, which generates federal Medicaid matching funds.

The distribution of the funds (both non-federal and federal) to eligible public and private hospitals is determined through negotiations with the Executive Director of CMAC. The Office of the President negotiates on behalf of the eligible medical centers. Eligible medical centers receive all of the funds transferred on their behalf by the Office of the President, as well as some portion of the federal matching funds. Payments by the Department of Health Services are made according to the following schedule:

Date of Payment (First Working Day of)	**Amount Paid (% of Total Payment)**
September	40%
November	30%
February	20%
April	10%

5. Process

CMAC announces, in writing, to eligible DSH hospitals that it has decided to conduct a round of SB 1255 negotiations. CMAC's letter invites hospitals that wish to participate in the current SB 1255 round to submit an "Intent to Participate" form by a specified date. An implementation schedule for the current SB 1255 round is also included, announcing the following deadlines: the date for submitting the hospital's proposal, which demonstrates the purpose for additional funding; the date of a voluntary IGT to the Emergency Services and Supplemental Payments Fund; the date for preliminary and final negotiations; and the dates for the preliminary report to CMAC by the Executive Director and the CMAC Board's action on recommendations.

The Office of the President coordinates the submission of each medical center's proposal to the Executive Director of CMAC. The Office of

II. SUPPLEMENTAL PAYMENT PROGRAM (Cont.)
B. SB 1255, MEDI-CAL EMERGENCY SERVICES AND SUPPLEMENTAL PAYMENTS PROGRAM (Cont.)
5. Process (Cont.)

the President also negotiates with the Executive Director of CMAC, on behalf of the individual medical centers, the amount that can be transferred by the University, as well as the amount to be paid to each eligible medical center. The Office of the President considers a number of issues prior to negotiations, including any potential OBRA '93 Cap problems at the medical centers.

Since all rate negotiations with CMAC are confidential, no formal documentation, such as an invoice, accompanies the Domestic Electronic Funds Transfer Request (Request) prepared by the Office of the President and submitted to the Office of the Treasurer after receiving the appropriate approvals. However, a copy of the May 17, 1990 minutes from the closed session of the Committee on Hospital Governance approving participation in the SB 1255 program and a copy of the letter from CMAC to the eligible medical centers inviting them to negotiate are attached. The funds are transferred to the Department of Health Services, Emergency Services and Supplemental Payments Fund from the Commercial Paper program on the date requested. The Department sends a receipt to the Office of the President acknowledging the University's voluntary IGT.

Upon receipt of a SB 1255 payment from the Department of Health Services, the medical center notifies the Office of Hospital Accounting of the date and amount received. The Office of Hospital Accounting prepares the necessary journals to recover funds to repay the Commercial Paper program for the funds transferred on behalf of an eligible medical center, as well as charge interest for the transferred funds. The interest charge is calculated at the Commercial Paper rate

from the date of transfer to the date the funds are recovered by the Office of the President (usually the same date that the funds are received by the medical center). The eligible medical center keeps the amount of SB 1255 funds that are in excess of the total voluntary IGT to be made on its behalf by the Office of the President in the payment year (the medical center's net benefit). The amount of SB 1255 funds received by the eligible medical center that is less than the voluntary IGT is recovered by the Office of the President to repay the Commercial Paper Program.

6. Budget

If negotiations for the SB 1255 program are completed between the Office of the President and the Executive Director of CMAC and the amount is approved by the CMAC Board within the fiscal year prior to payment, the medical centers have a right to the SB 1255 funds effective in the fiscal year of payment. The medical centers record the full amount of the net benefit of SB 1255 funds when preparing their full year budget and their full year projections. The medical centers record 1/12th of the full amount of the net benefit of SB 1255 funds that have been negotiated and approved in their monthly financial reports, effective July 1.

If negotiations for the SB 1255 program are completed between the Office of the President and the Executive Director of CMAC within the fiscal year in which payment is made, the medical centers do not have a right to the SB 1255 funds until the CMAC Board approves the negotiations. Therefore, the medical centers record the budgeted full net benefit amount as instructed by the Office of the President when preparing their full year budget and their full year projections. The medical centers shall neither budget nor accrue an amount in their monthly Hospital Activity and Financial Report to The Regents

II. SUPPLEMENTAL PAYMENT PROGRAM (Cont.)

B. SB 1255, MEDI-CAL EMERGENCY SERVICES AND SUPPLEMENTAL PAYMENTS PROGRAM (Cont.)

6. Budget (Cont.)

until they have an irrevocable right to these funds.

7. Accounting And Reporting

a. Office of the President

As the voluntary IGT is not made directly by a medical center, the transfer is not recorded in the medical center's books and records. The amount of funds transferred is recorded by the Office of the President as a receivable (i.e., SB 1255 Receivable - J-112090).

b. Recovery of Transferred Funds and Interest Charged on those funds by the Office of the President

The Office of the President prepares the necessary journals to recover funds transferred to the Department of Health Services on behalf of the medical centers that are eligible to participate in the SB 1255 program. The transferred funds are recovered following the receipt of the funds by the medical centers from DHS.

The Office of the President entries for the recovery of the transferred funds are:

Dr. Campus Financial Control
J-1195XX-0900XX-0
Cr. Current Fund CP Liability
J-101691-001729-0

Dr. CP Liability Control
M-115664
Cr. SB 1255 CP Receivable
M-112090

The Office of the President entries for the interest charge on the transferred funds are:

Dr. Campus Financial Control
J-1195XX-0900XX-0
Cr. Commercial Paper
J-101729-001729-0-2274

c. Medical Centers

If the CMAC Board has not approved the amount of SB 1255 funds to be distributed by hospital prior to the fiscal year of payment, nothing is budgeted or recorded in the Hospital Activity and Financial Status Report to The Regents. Only after the CMAC Board approves the amount of SB 1255 funds by medical center does the medical center have an irrevocable right to the funds. Upon receiving approval, the eligible medical centers can budget and book 1/12 of their full net benefit for each month from July 1 to the month in which CMAC's approval is granted. Every month thereafter, the medical centers accrue 1/12 of the full net benefit of SB 1255 funds.

SB 1255 payments are considered to be supplemental payments for services provided to Medi-Cal patients, but not to specific patients or services; therefore, the medical centers make the following entries:

The medical centers accrue 1/12th of the net benefit (i.e., the difference between the total payment to be received and the voluntary IGT made on behalf of the medical center) as follows:

Dr. Other Receivables
Cr. Contractual Allowance - Medi-Cal

II. SUPPLEMENTAL PAYMENT PROGRAM (Cont.)

B. SB 1255, MEDI-CAL EMERGENCY SERVICES AND SUPPLEMENTAL PAYMENTS PROGRAM (Cont.)

7. Accounting And Reporting (Cont.)

1) To record cash payment of SB 1255 funds:

Dr. Cash
Cr. Other Receivables - (Total SB 1255 payment)

2) Reversing entry on the medical center's books before recovery of funds transferred by OP:

Dr. Other Receivables
Cr. Cash due to Financial Control (Report as "Contra Cash on the medical center's Balance Sheet)[2]

3) Journal entry when the transferred amount is recovered by OP:

Dr. Other Receivables - (for amount transferred by OP)
Cr. Financial Control

C. MEDI-CAL MEDICAL EDUCATION PAYMENT PROGRAM

1. Definition

The Medi-Cal Medical Education Program provides a supplemental payment fund in recognition of medical education costs (both direct and indirect costs) associated with inpatient health care services rendered to Medi-Cal beneficiaries. The Medi-Cal Medical Education Program created two funds: 1) the Medi-Cal Medical Education Supplemental Payment Fund (Fund A), and 2) the Medi-Cal Large Teaching Emphasis Hospital and Children's Hospital Medical Education

[2] Same as footnote one.

Supplemental Payment Fund (Fund B). The voluntary transfers are matched by federal Medicaid funds for distribution to eligible hospitals after negotiations with the Executive Director of CMAC. By law, rates negotiated with CMAC are confidential; therefore, Med Ed negotiations are confidential.

2. Eligibility

Medi-Cal contracting hospitals that meet the definition of university teaching hospitals or major (non-university) teaching hospitals defined in the Department of Health Services report dated May, 1991, "Hospital Peer Grouping," are eligible to negotiate for funds from the Medi-Cal Medical Education Supplemental Payment Fund (Fund A). Contracting hospitals that are either: (1) a large teaching emphasis hospital, as defined in "Hospital Peer Grouping," or (2) a children's hospital pursuant to Section 10727 and meeting the definition of an eligible hospital as defined in Section 14105.98(a)(3) of the Welfare and Institutions Code, are eligible to negotiate for funds from the Medi-Cal Large Teaching Emphasis Hospital and Children's Hospital Medical Education Supplemental Payment Fund (Fund B).

3. Funding

The Medi-Cal Medical Education Program is funded from non-federal and federal sources. The non-federal funds come from voluntary IGTs by public agencies and other federally permissible private donations. The non-federal funds are matched by federal Medicaid funds, approximately dollar for dollar. The size of the federal match changes annually.

The amount of funding available to eligible hospitals is limited by the overall program size (IGT, donations, and federal matching funds) and the cost of medical education attributable to service provided to Medi-Cal beneficiaries.

II. SUPPLEMENTAL PAYMENT PROGRAM (Cont.)
C. MEDI-CAL MEDICAL EDUCATION PAYMENT PROGRAM (Cont.)

4. Distribution

Both federal and non-federal funds (Fund A - the Medi-Cal Medical Education Supplemental Payment Fund, and Fund B - the Medi-Cal Large Teaching Emphasis Hospital and Children's Hospital Medical Education Supplement Payment Fund) are distributed to eligible hospitals following negotiations with the Executive Director of CMAC. The medical centers can only receive a distribution from Fund A. The negotiations for these funds are conducted between the Office of the President and the Executive Director of CMAC in recognition of teaching costs associated with Medi-Cal inpatients. Medi-Cal Medical Education funds pay for direct medical education costs, as reported on the most recent audited Medi-Cal cost report, and some portion of indirect medical education costs, which is calculated by multiplying direct medical education costs by three. The distribution of funds to the medical centers usually consists of the University's voluntary transfer and some portion of the federal matching funds. Department of Health Services distributes the funds to eligible hospitals in an annual payment, usually in June.

5. Process

CMAC notifies hospitals that are eligible to negotiate for Medi-Cal Medical Education funds. A hospital intending to participate must submit the "Intent to Participate" form to CMAC. The CMAC letter notification also includes an implementation schedule for Medical Education Fund negotiations, which sets dates for the following: voluntary IGTs to the Medical Education Fund; submission of a written proposal for the supplemental funding in recognition of medical education costs incurred for inpatient services rendered to Medi-Cal beneficiaries; negotiations with the Executive Director of CMAC;

and actions by the CMAC Board. Each medical center submits the Intent to Participate form directly to the Executive Director of CMAC.

The proposal from each medical center is sent to the Office of the President for coordination and submission to the Executive Director of CMAC. The Office of the President requests that the medical centers complete a template with Medi-Cal direct and indirect medical education costs from the most recent audited Medi-Cal cost report. Data from these templates are used to determine the maximum costs that qualify for Medi-Cal Medical Education funding. The data is helpful when the Office of the President negotiates with the Executive Director of CMAC on behalf of the medical centers for Medical Education funding. Medi-Cal Medical Education funds for the medical centers are from Fund A - the Medi-Cal Medical Education Supplemental Payment Fund.

Based on the outcome of the negotiations with the Executive Director of CMAC, the Office of the President submits a voluntary IGT to the Department of Health Services. As part of the negotiations with the Executive Director of CMAC, the University has made voluntary IGTs to Fund B - the Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund.

Following the negotiations, the Office of Hospital Accounting prepares a check request form and attaches a copy of the letter from CMAC to the medical centers informing them that they are eligible to negotiate for Medi-Cal Medical Education funds. Since the medical centers negotiate with CMAC for an increase in Medi-Cal rates, the negotiations are confidential; therefore, no formal documentation, such as an invoice, is available to attach to the check request.

II. SUPPLEMENTAL PAYMENT PROGRAM (Cont.)
C. MEDI-CAL MEDICAL EDUCATION PAYMENT PROGRAM (Cont.)
5. Process (Cont.)

The Office of Hospital Accounting prepares the check request and submits it to the Treasurer after receiving the appropriate approvals. The check is sent to the Department of Health Services on the date requested. Funds are drawn from the Commercial Paper program for the voluntary IGT. The Department of Health Services sends a receipt to the Office of the President acknowledging the University's voluntary IGT.

The medical centers do not have an irrevocable right to the Medi-Cal Medical Education funds until the CMAC Board approves the program and the amendments to the medical center's Medi-Cal contract are approved.

The Medi-Cal Medical Education funds are distributed in one payment to the medical centers. Upon receipt of the Medical Education funds, the medical center notifies the Office of Hospital Accounting of the date the payment was received. The Office of Hospital Accounting prepares the necessary journals to recover funds to repay the Commercial Paper program for the funds transferred on behalf of a medical center, as well as charge interest on the transferred funds. The interest charge is calculated at the Commercial Paper rate from the date of transfer to the date the funds are recovered by the Office of the President (usually the same date that the funds are received by the medical center).

The 1997 State budget appropriated $500,000 as an augmentation to the Charles R. Drew University of Medicine and Science and required the University of California to provide equivalent matching funds. The availability of Medi-Cal Medical Education funds has allowed the University to release funds from its existing budget to provide the required matching funds for Drew. The University of California has elected to use

Clinical Teaching Support (CTS) funds in lieu of Medical Education funds because Drew is ineligible for Medical Education funding. The Office of Hospital Accounting prepares the necessary journals to reallocate CTS from the medical centers to the Drew School of Medicine.

6. Budget

The Office of the President provides an anticipated amount of Medical Education funds that can be budgeted by the medical centers. This amount is recorded by the medical centers when preparing their full year budget and their full year projections. Since the medical center do not have an irrevocable right to the Medical Education funds until the CMAC Board approves the amount and the amendments to the medical center's Medi-Cal contract, the medical centers shall neither budget nor accrue an amount in their monthly financial report.

7. Accounting And Reporting

a. Office of the President

Since the voluntary IGT is not made directly by a medical center, the transfer is not recorded in the medical center's books and records. The amount of funds transferred is recorded by the Office of the President as a receivable (i.e., Medi-Cal Medical Education Receivable - J-112090).

b. Recovery of Transferred Funds and Interest Charged on those Funds by the Office of the President

The Office of the President prepares the necessary journals to recover funds transferred to the Department of Health Services on behalf of the medical centers' participation in the Medi-Cal Medical

II. SUPPLEMENTAL PAYMENT PROGRAM (Cont.)
C. MEDI-CAL MEDICAL EDUCATION PAYMENT PROGRAM (Cont.)
7. Accounting And Reporting (Cont.)
b. Recovery of Transferred Funds and Interest Charged on those Funds by the Office of the President (Cont.)

Education Program. The funds shall be recovered following the receipt of the funds by the medical centers.

The Office of the President entries for the recovery of the transferred funds are:

Dr. Campus Financial Control
J-1195XX-0900XX-0
Cr. Current Fund CP Liability
J-101691-001729-0

Dr. CP Liability Control
M-115664
Cr. Med Ed CP Receivable
M-112090

The Office of the President entries for the interest charge on the transferred funds are:

Dr. Campus Financial Control
J-1195XX-0900XX
Cr. Commercial Paper
J-101729-001729-0-2274

c. Medical Centers

The medical centers do not accrue any amount for Medi-Cal Medical Education funds until the CMAC Board approves both the amount of funding and the amendments to the medical center's Medi-Cal contract. If the approval occurs after the start of the fiscal year, the medical centers can budget and book 1/12 of their full net benefit for each month from July 1 to the month CMAC’s approval is granted. For the remaining months in the

fiscal year, the medical centers record 1/12th of the full amount of the net benefit of Medical Education funds.

The medical centers make the following entries:

Med Ed Funds:

(1) Accrual of Medical Education Funds
Dr. Other Receivables
Cr. Contractual Allowance - Medi-Cal

(2) Receipt of Medical Education Payment
Dr. Cash
Cr. Other Receivables

(3) Reversing entry on the medical center's books before recovery of funds transferred by OP:
Dr. Other Receivables
Cr. Cash due to Financial Control
(Report as Contra Cash on the medical center's balance sheet)[3]

(4) Journal entry when the transferred amount is recovered by OP:
Dr. Other Receivables (for amount transferred by OP)
Cr. Financial Control

CTS Funds:

Reallocation of CTS Funds for Drew Medical School

Medical Center Entries
Dr. Hospital Other Operating Revenue - CTS 263XXX-63000
Cr. Cash

[3] Same as footnote one.

II. SUPPLEMENTAL PAYMENT PROGRAM (Cont.)

C. MEDI-CAL MEDICAL EDUCATION PAYMENT PROGRAM (Cont.)

7. Accounting And Reporting (Cont.)

c. Medical Centers (Cont.)

Campus Entries
Dr. Unexpended Fund Balance
X-119900-19900-0-0800
Cr. Financial Control

D. SB 1732, MEDI-CAL CONSTRUCTION AND RENOVATION REIMBURSEMENT PROGRAM

1. Definition

SB 1732 - The Construction and Renovation Reimbursement Program provides supplemental Medi-Cal reimbursement to disproportionate share hospitals for debt service cost (principal and interest) of approved capital construction. Eligible hospitals must meet with the Department of Health Services to determine which capital projects will be covered, payment amounts, and payment schedules. While the SB 1732 program is administered by the Department of Health Services, the payment authority is incorporated into the Selective Provider Contracting Program's hospital contracts under CMAC.

2. Eligibility

An eligible hospital must be a DSH and must have Office of Statewide Health Planning and Development’s approval for capital construction projects that were started prior to June 30, 1996. CMAC approves funding for these capital construction projects.

3. Funding

Medi-Cal funds appropriated in the state budget are matched with federal Medicaid funds.

4. Distribution

Payment of approved construction costs is based upon the medical center's Medi-Cal utilization rate (i.e., percentage of Medi-Cal utilization times the amount of approved construction costs). Reimbursement of SB 1732 funds is initiated by the eligible hospital by sending loan payment documents from the trustee to the Department of Health Services. Checks are sent twice a year from the Department of Health Services to eligible hospitals.

5. Process

Hospitals apply to the Department of Health Services for funding to finance construction projects. The Department determines which projects are eligible for SB 1732 funding, the amount of SB 1732 funds, and a payment schedule. When an agreement has been reached between the hospital and the Department of Health Services, the Department notifies CMAC to amend the hospital's Medi-Cal contract in order to receive this supplemental payment.

The Department of Health Services sends a letter to eligible hospitals requesting estimates of anticipated gross debt service payments and the anticipated dates of those payments for the next two fiscal years. The payment estimates assist the Department in requesting funding in the state budget. The Department issues a check twice a year to the eligible hospital to be used to pay principal and interest on the approved capital construction projects. Reimbursement for construction projects under the Construction/Renovation Reimbursement Program (CRRP) is calculated by multiplying the hospital’s debt service obligations times its CRRP Medi-Cal utilization percentages in effect for the covered period.

II. SUPPLEMENTAL PAYMENT PROGRAM (Cont.)

D. SB 1732, MEDI-CAL CONSTRUCTION AND RENOVATION REIMBURSEMENT PROGRAM (Cont.)

5. Process (Cont.)

All documents verifying payment of debt service must be submitted to the Department of Health Services annually and are subject to audit by the Department.

6. Budget

After the eligible hospital sends a copy of the loan payment documents from the trustee to the Department of Health Services, the Department sends a letter to the hospital with an attached calculation of how the SB 1732 payments for the fiscal year were determined. The medical centers record the full amount when preparing their full year budget and their full year projection. The medical centers record 1/12th of the full amount of expected SB 1732 funds in their monthly financial report.

7. Accounting and Reporting

Although the SB 1732 funds are used for capital construction, the Office of Statewide Health Planning and Development requires that the SB 1732 funds be recorded as operating revenue.

The medical centers accrue 1/12th of the expected annual amount of SB 1732 funds, as follows:

Dr. Other Receivables
Cr. Contractual Allowances - Medi-Cal

When the payments are received, the following entries are made:

Dr. Cash
Cr. Other Receivables.

III. RESPONSIBILITIES

A. CHANCELLORS AND MEDICAL CENTER DIRECTORS

Chancellors and medical center directors have the responsibility to ensure that the procedures set forth in this chapter are uniformly and consistently applied and followed by their respective campus medical centers and health care facilities. They may delegate adequate authority to their respective medical center finance officers for purposes of implementing the procedures set forth in this chapter.

B. MEDICAL CENTER FINANCE OFFICERS

Medical center finance officers, in consultation with their respective campus accounting officers and/or the Office of Medical Center Budget and Finance, at the Office of the President, as necessary, are responsible for the local application of the procedures set forth in this chapter.

IV. REFERENCES

SB 855 Program - Welfare and Institutions Code, Section 14105.98

SB 1225 Program - Welfare and Institutions Code, Section 14085.6

Medi-Cal Medical Education Program - Welfare and Institutions Code, Section 14085.7

SB 1732 Program - Welfare and Institutions Code, Section 14085.5

Coordinator Turek, Letter to Hospital Finance Directors on Accounting for SB 855 and SB 1255 Funds, May 30, 1997.

Coordinator Turek, Letter to Hospital Finance Directors on SB - Secondary Supplemental Lump-Sum Payment Adjustment 1999-90, June 14, 2000.

IV. REFERENCES (Cont.)

Coordinator Turek, Letter to Hospital Finance Directors on Medi-Cal Medical Education Supplemental payment Program, May 21, 2001.

Coordinator Turek, Letter to Hospital Finance Directors at Davis, Irvine and San Diego on SB 1732 Funds, July 12, 1999.

Historical note: Original Accounting Manual chapter first published 6/30/01. Analyst--John Turek.

End.