Health Services
LOS ANGELES COUNTY

June 03, 2025

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LOS ANGELES COUNTY

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313 N. Figueroa Street, Suite 912
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Tel: (213) 288-8050
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The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

APPROVAL OF FUNDING METHODOLOGY AND AMENDMENTS TO THE MEMORANDUM OF AGREEMENTS FOR NON-COUNTY TRAUMA CENTER PROVISIONS FOR REIMBURSEMENT (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)

SUBJECT

Request the approval of a funding methodology and allocation of funding to non- County trauma centers for Fiscal Year (FY) 2024-25, and for delegation of authority to extend the term of the Trauma Center Provisions for Reimbursement Memorandum of Agreement (MOA) through June 30, 2026, which will contain the reimbursement provision for FY 2024-25 and approval of an allocation of funds to County hospitals.

IT IS RECOMMENDED THAT THE BOARD:

1. Approve the funding methodology and allocation of the Trauma Center Provisions for Reimbursement (TCPR) for FY 2024-25, and authorize the Director of Health Services (Director), or authorized designee, to execute amendments to the TCPR MOA, substantially similar to Exhibit I, with 13 non-County trauma centers to extend the term for the period July 1, 2025 through June 30, 2026, and include the funding terms for the period July 1, 2024 through June 30, 2025, for a total Los Angeles County (LA County) obligation of approximately $58.806 million (comprised of $55.716 million from the Measure B funds, $2.329 million from the Maddy Emergency Medical Services Fund (Maddy Fund), and $0.761 million from the Richie's Fund, as set forth in Attachment A and described below.)

2. Approve and authorize the Director, or authorized designee, to allocate up to a maximum of $41.346 million of the Measure B funds to be used as an Intergovernmental Transfer (IGT) to the California Department of Health Care Services to draw down Federal matching dollars for supplemental Medi-Cal payments to eligible non-County trauma centers.

3. Approve and authorize the Director, or authorized designee, to allocate the amount of $0.080 million from the Richie's Fund to the two LA County Pediatric Trauma Centers listed in Attachment A.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Funding Methodology Background

Prior to the implementation of the Affordable Care Act (ACA) in January 2014, the methodology used to distribute trauma funding to non-County trauma centers was largely based on trauma claims for the uninsured population. After the ACA was implemented and its impact became more widespread, there was a significant reduction in the volume of uninsured trauma claims. Beginning in FY 2014-15, the number of uninsured trauma claims was too minimal to allow the full allocation of Measure B funds. In light of the significant and continuing decrease in the number of uninsured, the non-County trauma centers expressed concerns and wanted to ensure they would continue to receive the same level of trauma funding as in years prior to the ACA. Therefore, on May 3, 2016, the Board of Supervisors (Board) approved an amendment to the Trauma Centers Agreements for FY 2014-15 which continued trauma funding to the non-County trauma centers for the same funding amounts received by the trauma centers in FY 2013-14.

Given the significant and continuing impact of the ACA, and to ensure that prior funding levels would be maintained, the non-County trauma centers deemed it necessary to develop a new basis for distributing trauma funds. Pursuant to discussions between the non-County trauma centers and the Department of Health Services (DHS), a new funding methodology for FY 2015-16 was developed that incorporated new categories for reimbursement, and which was approved by the Board on November 1, 2016.

During FY 2016-17, the non-County trauma centers advised that funding levels should be maintained at levels similar to prior fiscal years, despite the severe decline in uninsured trauma patients. As such, the funding methodology that was approved for the fiscal year was based on the following: the level of indigent services, the provision of base station services, and a flat amount to support infrastructure. In addition, and recognizing the continuing ACA impact, the non-County trauma centers identified other add-on factors to be used as a basis for the distribution of the FY 2016-17 trauma funds at levels similar to prior years. The add-ons selected by the non-County trauma centers and approved by DHS were as follows: 1) an adjustment for the volume of trauma patients; 2) an adjustment for the level of acuity of trauma patients; and 3) an adjustment for the number of Medi-Cal days and visits, which serves as a proxy for the underinsured population. Lastly, to address concerns that the application of the proposed FY 2016-17 formula would impact each trauma center to a greater or lesser degree, a parity adjustment was made in proportion to the degree of positive or negative impact to assure that no trauma center would be affected disproportionately. The FY 2016-17 methodology was approved by the Board on May 16, 2017.

For FY 2017-18, in conjunction with all 13 non-County trauma centers, DHS reached a consensus for utilizing the basic methodology components from FY 2016-17, but with the following modifications: 1) including a parity adjustment to reduce the decrease in funding received by a

trauma center in comparison to the prior fiscal year; 2) information about services was included with the Medi-Cal information given to patients who were brought in by law enforcement to determine the component related to underinsured populations; and 3) the allocation of pediatric trauma payments to each pediatric trauma center from Richie's Funds for pediatric trauma services was based on the facility type. Since Dignity Health-Northridge Hospital Medical Center is the only pediatric trauma center in LA County operating as a community hospital, it was given a larger allocation than the remaining pediatric trauma centers, which are tertiary trauma centers. The FY 2017-18 methodology was approved by the Board on June 6, 2018.

DHS and all 13 non-County trauma centers reached a consensus for utilizing the same components used in the FY 2017-18 methodology for FY 2018-19. FY 2018-19 funding also included a one-time allocation of unspent Measure B funds from FY 2017-18 for the trauma centers as recommended by the Measure B Advisory Board (MBAB), which was presented by the Chief Executive Office (CEO) to the Board on March 12, 2019. The FY 2018-19 methodology was approved by the Board on May 21, 2019.

For FY 2019-20, DHS again reached a consensus with the 13 non-County trauma centers to use the funding methodology used in the previous FY, including a recommendation by the MBAB for a one-time allocation of unspent Measure B funds from FY 2018-19, which was presented by the CEO to the Board on February 11, 2020. The FY 2019-20 methodology was approved by the CEO on June 1, 2020, by delegated authority.

For FY 2020-21, DHS again reached a consensus with the 13 non-County trauma centers to use the funding methodology used in the previous FY, but without the one-time allocation of unspent and unallocated Measure B funds, as recommended by the MBAB. The FY 2020-21 methodology was approved by the Board on June 22, 2021.

For FY 2021-22, DHS again reached a consensus with the 13 non-County trauma centers to use the funding methodology used in the previous FY, including a recommendation by the MBAB for a one-time allocation of unspent Measure B funds from FY 2020-21, which was presented by the CEO to the Board on February 7, 2022. The FY 2021-22 methodology was approved by the Board on June 14, 2022.

For FY 2022-23, DHS and all 13 non-County trauma centers reached a consensus for utilizing the same components used in the FY 2021-22 methodology for FY 2022-23 with the following modifications: 1) no parity adjustment to mitigate the change in funding received by a trauma center in comparison to the prior fiscal year and the one-time allocation of unspent and unallocated Measure B funds, per recommendation by the MBAB; and 2) an annual ongoing Measure B Funding of $8.957 million, per the Measure B property assessment rate increase, which the Board approved on September 13, 2022. Of this amount, $5.957 million was allocated to all 13 non-County trauma centers to support ongoing investments to maintain and/or expand the regional trauma care system, while $3 million was allocated to five pediatric trauma hospitals to support ongoing investments in pediatric trauma care. The FY 2022-23 methodology was approved by the Board on June 6, 2023.

For FY 2023-24, DHS and all 13 non-County trauma centers reached a consensus for utilizing the same components used in the FY 2022-23 methodology. FY 2023-24 funding also included a one-time allocation of unspent Measure B funds for the trauma centers as recommended by the MBAB, which was presented by the CEO to the Board on January 24, 2024. The FY 2023-24 methodology was approved by the Board on June 4, 2024.

FY 2024-25 Distribution Methodology

For FY 2024-25, DHS and all 13 non-County trauma centers reached a consensus for utilizing the same components used in the FY 2023-24 methodology, without any approved MBAB projects which would use unspent and unallocated Measure B funds.

The proposed FY 2024-25 payments to each non-County trauma center are summarized in Attachment A.

TCPR MOA Background

Prior to June 30, 2021, the trauma center designation process requirements, and provisions for reimbursement were covered under a Trauma Center Services Agreement as a means to provide supplemental funding to offset operating expenses related to trauma center operations. On June 22, 2021, DHS split the two actions and executed TCPR MOAs for the continued implementation of reimbursement provisions for designated trauma centers. The trauma center designation for each hospital was added, by way of an amendment, and under delegated authority by the Board, to the Specialty Care Center Designations Master Agreement, which was approved by the Board on June 11, 2019.

Summary of Recommendations

Approval of the Recommendations will ratify the funding methodology and delegate authority to the Director, or authorized designee, to execute the amendments to the TCPR MOAs, substantially similar to Exhibit I, to include financial terms for FY 2024-25, extend the term of the MOAs for an additional one (1) year period, process payments for FY 2024-25, and submit an IGT to draw down federal matching funds for those portions of the payments that are to be made as Medi-Cal supplements. These amendments permit the continued provision of Measure B funding to trauma centers which help to secure emergency care access for Medi-Cal beneficiaries, stabilize the trauma care system in LA County, and allow sufficient time for the development of a funding methodology for FY 2025-26.

Implementation of Strategic Plan Goals

These recommendations support LA County's Strategic Plans: North Star 3, Goal G, Strategy i. – "Maximize Revenue;" North Star 3, Goal A, Strategy i., "Customer Service;" and North Star 1, Goal A, Strategy ii., "Improve Health Outcomes."

FISCAL IMPACT/FINANCING

The total maximum payment for the above-recommended actions under the MOAs for FY 2024-25 is approximately $100.232 million, including $58.886 million of LA County funds (Measure B: $55.716 million; Maddy Fund: $2.329 million, and Richie's Fund: $0.841 million, which includes $0.080 million in funds for the two County pediatric trauma hospitals) and $41.346 million of Federal matching funds, which was calculated based on a federal matching rate of 50%. Funding for LA County responsible portion of the TCPR MOAs is included in DHS' FY 2024-25 Final Budget. The MOAs are fully funded by the Measure B, Maddy funds, and Richie's funds. There is no net County cost impact associated with the recommendations.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Pursuant to the authority under California Health and Safety (H&S) Code Section 1798.160, LA County maintains trauma facilities as part of the regional trauma care system for the treatment of potentially seriously injured persons. Division 2.5 of the H&S Code authorizes the local Emergency Medical Services Agency to designate trauma centers as part of the regional trauma care system. Since March 1, 2017, there have been 13 non-County and two LA County-operated trauma centers.

The TCPR MOAs are designed to provide supplemental funding to offset the significant expenses related to maintaining trauma designation and treating trauma patients. The FY 2024-25 TCPR MOAs are funded by the Measure B, Maddy Fund, and Richie's funds and contemplate the State making IGT-funded supplemental Medi-Cal payments to non-public trauma centers in LA County.

Measure B Funds

Measure B, passed by the voters on November 5, 2002, authorized LA County to levy a tax on structural improvements within LA County, in part to provide funding to strengthen LA County trauma network, particularly those trauma centers operated by LA County, expand the trauma network if possible, and to fund emergency medical services and bioterrorism preparedness. Subsequent to Measure B's passage, the Board approved multiple proposals to allocate Measure B funds among the non-County trauma centers. The Board also approved payments to reimburse trauma centers for costs associated with serving as a base hospital in the Emergency Medical Services system.

The Maddy and Richie's Funds

LA County receives funds collected from penalties assessed on fines and bail forfeitures that the Superior Court collects for certain criminal offenses and motor vehicle violations. As permitted by California Government Code Section 76000.5 and H&S Code Section 1797.98a, these funds are placed in LA County's Maddy Fund and used by DHS for trauma and emergency services. A portion of the Maddy Fund is designated by statute for support of pediatric trauma programs and is segregated as the Richie's Fund. The remaining Maddy Fund dollars are available to support trauma and emergency services provided by hospitals and physicians.

Medi-Cal Payments

The California State Plan, starting at page 51 of Attachment 4.19B, permits the California Department of Health Care Services to make supplemental Medi-Cal payments to non-public trauma centers in LA County. LA County makes recommendations regarding the amount of the supplemental payments and provides the funding for the non-federal share of such payments through an IGT.

County Counsel has reviewed and approved Exhibit I as to form.

CONTRACTING PROCESS

Not applicable.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommendations will assure continued participation of non-County trauma centers in LA County's trauma network and provide trauma funding for FY 2025-26.

Respectfully submitted,

Christina R. Ghaly, M.D.
Director

CRG:jr:fl

Enclosures

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
LOS ANGELES COUNTY TRAUMA CARE SYSTEM

PROPOSED PAYMENTS TO NON-COUNTY TRUAMA HOSPITALS
FISCAL YEAR 2024-25

Attachment A

	Patient-Based	Pediatric	Designation Support		Add-Ons			Additional Funding (Measure B Rate Increase)		Total Payments (1) thru (9)
	(1) UNINSURED (Volume)	(2) PEDIATRIC (Fixed Rate)	(3) BASE STATION (Fixed Rate)	(4) INFRASTRUCTURE (Fixed Rate)	(5) TRAUMA (Volume)	(6) ACUITY (Adjustment)	(7) UNDERINSURED (Adjustment)	(8) TRAUMA HOSPITALS (Adjustment)	(9) PEDIATRIC HOSPITAL (Adjustment)	
Non-County Hospitals										
Antelope Valley Hospital	$ 367,090	$ -	$ 700,000	$ 1,200,000	$ 1,288,979	$ 557,796	$ 2,291,623	$ 792,308	$ -	$ 7,197,796
Dignity Health-California Hospital Medical Center	2,595,479	-	700,000	1,200,000	1,720,458	776,640	4,059,715	1,367,082	-	12,419,374
Cedars-Sinai Medical Center	193,131	40,180	700,000	1,200,000	1,467,396	760,340	2,318,792	821,274	340,958	7,842,071
Children's Hospital Los Angeles	-	40,180	-	1,200,000	525,241	152,134	629,595	310,092	2,631,640	5,488,882
Henry Mayo Newhall Hospital	103,417	-	700,000	1,200,000	696,376	252,236	788,431	462,666	-	4,203,126
Huntington Hospital	40,521	-	700,000	1,200,000	1,508,359	569,551	1,213,212	647,114	-	5,878,757
MemorialCare Long Beach Medical Center	111,885	40,180	700,000	1,200,000	1,614,864	631,429	2,246,689	804,602	1,125,286	8,474,935
Dignity Health-Northridge Hospital Medical Center	1,134,380	600,000	700,000	1,200,000	1,455,562	613,589	2,231,537	907,290	849,316	9,691,674
Pomona Valley Hospital Medical Center	463,850	-	700,000	1,200,000	1,552,054	692,480	2,046,054	823,102	-	7,477,540
Providence Holy Cross Medical Center	1,759,257	-	700,000	1,200,000	1,177,012	511,953	2,199,665	933,614	-	8,481,501
Ronald Reagan UCLA Medical Center	503,534	40,180	700,000	1,200,000	1,301,722	627,940	2,002,166	783,634	526,400	7,685,576
St. Francis Medical Center	234,658	-	700,000	1,200,000	1,637,621	681,321	3,432,732	975,478	-	8,861,810
Dignity Health-St. Mary Medical Center	680,756	-	700,000	1,200,000	814,715	406,124	1,936,855	709,802	-	6,448,252
Subtotal Non-County Hospitals	$ 8,187,958	$ 760,720	$ 8,400,000	$ 15,600,000	$ 16,760,359	$ 7,233,533	$ 27,397,066	$ 10,338,058	$ 5,473,600	$ 100,151,294
County Hospitals										
Los Angeles General Medical Center	$ -	$ 40,180	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 40,180
Harbor-UCLA Medical Center	-	40,180	-	-	-	-	-	-	-	40,180
Subtotal County Hospitals	$ -	$ 80,360	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 80,360
Grand Total:	**$ 8,187,958**	**$ 841,080**	**$ 8,400,000**	**$ 15,600,000**	**$ 16,760,359**	**$ 7,233,533**	**$ 27,397,066**	**$ 10,338,058**	**$ 5,473,600**	**$ 100,231,654**

Col (1) - Payment is based on each hospital's share in the total value of the FY 2023-24 indigent claims submitted by non-County trauma hospitals to the County (net of FY 2022-23 disallowed claims), multiplied by the total funding allocated for this category.

Col (2) - Payment is based on facility type. Northridge Hospital Medical Center receives a larger allocation due to its State-designated status as a Pediatric Community Hospital.

Col (3) - Fixed payment for each hospital that provides base hospital service meeting the requirement of County's Emergency Medical Services Agency.

Col (4) - Infrastructure is a fixed payment for each trauma hospital to defray the trauma call panel, specialist physicians and trauma program costs.

Col (5) - Trauma payment is based on each hospital's percentage in the total trauma patient volume of non-County trauma hospitals (reported by County's TEMIS for CY 2023) multiplied by the total funding allocated for this category.

Col (6) - Acuity payment is based on each hospital's percentage in the total patient days of non-County trauma hospitals (reported by County's TEMIS for CY 2023) that are adjusted for severity factors, multiplied by the total funding allocated for this category.

Col (7) - Underinsured payment is based on each hospital's percentage in the total Medi-Cal and In-Custody patient days of non-County trauma hospitals (reported by County's TEMIS for CY 2023), multiplied by the total funding allocated for this category.

Col (8) - Payment is based on each hospital's percentage of the grand total from columns 1 - 7 (except column 2) for each hospital, multiplied by $5.957 million, then distributed so that the two public hospitals (Antelope Valley Hospital and Ronald Reagan UCLA Medical Center) receive funding directly from the County in amounts equivalent to the amounts they would have received if they were eligible for State matching.

Col (9) - Payment is based on similar calculation with columns 5, 6 and 7, but using only pediatric data.

EXHIBIT I

Agreement No. H-_____

MEMORANDUM OF AGREEMENT
FOR
NON-COUNTY TRAUMA CENTER PROVISIONS FOR REIMBURSEMENT

Amendment No. 4

THIS AMENDMENT is made and entered into this _____ day of June, 2025,

By and between COUNTY OF LOS ANGELES
(hereinafter "County"),

And

ABC HOSPITAL
(hereinafter "Hospital").

Business Address:

XX
XX

WHEREAS, reference is made to that certain document entitled " MEMORANDUM OF AGREEMENT FOR NON-COUNTY TRAUMA CENTER PROVISIONS FOR REIMBURSEMENT" dated on June 11, 2021, and further identified as Agreement No.:_____, including any amendments and any other modifications thereto (cumulatively hereafter referred to as "MOA"); and

WHEREAS, the Board of Supervisors approved reimbursement to the Non-County Trauma Hospitals using funding provided by Measure B, the EMS Maddy Fund, and Richie's Fund.

WHEREAS, on June 3, 2025, the County's Board of Supervisors delegated authority to the Director of Health Services, or authorized designee, to, among other delegations, to execute amendments to the MOA to extend the term of the MOA for the period July 1, 2025 through June 30, 2026, to provide for funding allocation for Fiscal Year 2025-26, for a total County obligation of approximately $58.806 million comprised of various amounts from Measure B, the EMS Maddy Fund, and Richie's Fund.

NOW THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

1. This Amendment shall be effective upon execution.

2. The MOA is hereby incorporated by reference, and all of its terms and conditions, including capitalized terms defined herein, shall be given full force and effect as if fully set forth herein.

3. The MOA, Paragraph 1.0 – SCOPE is deleted in its entirety and replaced to read as follows:

"1.0 SCOPE

1.1 This MOA addresses funding through the fiscal year ending June 30, 2025 (the "Contract Period") for non-County trauma hospitals in Los Angeles County having trauma centers ("Non-County Trauma Hospitals"). Non-County Trauma Hospitals are hospitals that are not owned nor operated by County of Los Angeles (the "County"). The County's funding to Non-County Trauma Hospitals for this contract period assures the continuance of emergency care access for Medi-Cal beneficiaries and stabilizes the provision of trauma care services in Los Angeles County.

1.2 The funding identified in this MOA for Non-County Trauma Hospitals, described in Exhibit A, Provisions For Reimbursement, covers the following four components:

1.2.1. Patient/Hospital-Based Payments
This component includes uninsured trauma claims and pediatric trauma services, as described in Exhibit A, Sections I and II.

1.2.2 Designation Support Payments
This component includes payments for Non-County Trauma Hospitals that serve as base stations and funding for trauma hospitals' infrastructure, as described in Exhibit A, Section III A.

1.2.3 Add-On Payments
This component includes payments for: a) trauma patient volume; b) patient acuity; c) the volume of underinsured patients (i.e., Medi-Cal and In-Custody patients); and d) a parity adjustment to mitigate the negative financial impact among various hospitals as described in Exhibit A, Section IV.

1.2.4 Measure B Advisory Board Funding (if available)
This component includes one-time payments, as applicable, if funding is available and recommended by the Measure B Advisory Board (MBAB), and approved by the County Board of Supervisors, to distribute prior year unspent and unallocated Measure B funds as described in Exhibit A, Section V.

1.3 The County intends to provide funding to Hospital for one or more of the four components described in Section 1.2 from the following fund sources under this MOA: Measure B, The EMS Maddy Fund, and Richie's Fund. In addition, the County will utilize Measure B funds, to the extent possible, to make an inter-governmental transfer (IGT) of funds to the California Department of Health Care Services (CDHCS) to draw down Federal matching dollars for enhanced Medi-Cal payments to Eligible Trauma Hospitals, pursuant to California's Medicaid State Plan (Title XIX), Attachment 4.19B (Enhanced Payments to Private Trauma Hospitals), pp. 51-51c (TN-03-032, app. Mar. 31, 2005; eff. Jul. 1, 2003), attached hereto as Attachment A.

1.4 The Non-County Trauma Hospitals entering into this MOA acknowledge that Attachment A, was approved by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services. Attachment A enables private trauma hospitals in Los Angeles County to receive additional Medi-Cal payments, under Section 14087.3 of the Welfare and Institutions Code. Pursuant to Medicaid State Plan and a related interagency agreement between the County and the CDHCS, these additional Medi-Cal payments are distributed to the County-designated private trauma hospitals, in a lump-sum amount to ensure continued access by Medi-Cal beneficiaries to trauma and emergency room care in the County."

4. The MOA, Paragraph 2.0 – TERM is deleted in its entirety and replaced to read as follows:

"2.0 TERM

2.1 The term of this MOA is effective upon the date of execution by the Director of Health Services (Director), or designee. This MOA shall expire on June 30, 2026, unless sooner extended or terminated, in whole or in part, as provided herein.

2.2 In any event, this MOA may be terminated for any reason at any time by either party by giving at least thirty (30) calendar days advance written notice to the other party."

5. The MOA, Paragraph 3.0 – PAYMENT AND INVOICES is deleted in its entirety and replaced to read as follows:

"3.0 PAYMENT AND INVOICES

3.1 County's maximum reimbursement amount to the Non-County Trauma Hospitals for the delivery of trauma services for fiscal years 2020-21, 2021-22, 2022-23, 2023-24, and 2024-25 shall not exceed the amounts identified in Exhibit A."

6. The MOA, Exhibit A- Provisions For Reimbursement is modified to add Exhibit A-4, attached hereto and incorporated herein by reference, to the existing Exhibits A, A-1, A-2, and A-3. Any reference to Exhibit A in the MOA shall include Exhibit A-4.

7. Except for the changes set forth hereinabove, the MOA shall not be changed in any respect by this Amendment.

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IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Amendment to be executed by the County's Director of Health Services, or authorized designee, and Hospital has caused this Amendment to be executed on its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By: _____ for
Christina R. Ghaly, M.D.
Director of Health Services

HOSPITAL

_____

By_____
Signature

_____
Printed Name

_____
Title

APPROVED AS TO FORM:

DAWYN R. HARRISON
County Counsel

By: _____
Sara Zimbler
Principal Deputy County Counsel

EXHIBIT I

DRAFT

MEMORANDUM OF AGREEMENT (MOA) EXHIBIT A-2
PROVISIONS FOR REIMBURSEMENT

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LISTING OF ATTACHMENTS

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4	TRAUMA SERVICES COUNTY ELIGIBILITY
5	HOSPITAL CERTIFICATION OF INABILITY TO COOPERATE
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TRAUMA CENTER PROVISIONS FOR REIMBURSEMENT

I. ELIGIBLE PATIENT-BASED FUNDING

A. BUDGET ALLOCATION

1. Patient-Based Allocation Amounts

This Section I is applicable to the Non-County Trauma Hospitals with the exception of Children's Hospital Los Angeles. For the Contract Period, the County has established a budget allocation (the "Budget Allocation") for each such Non-County Trauma Hospital providing medical care to Eligible Patients (as defined below) during the Contract Period. The budget allocations are as follows:

Antelope Valley Hospital	$ 367,090
Dignity Health-California Hospital Medical Center	$2,595,479
Cedars-Sinai Medical Center	$ 193,131
Henry Mayo Newhall Hospital	$ 103,417
Huntington Hospital	$ 40,521
MemorialCare Long Beach Medical Center	$ 111,885
Dignity Health-Northridge Hospital Medical Center	$1,134,380
Pomona Valley Hospital Medical Center	$ 463,850
Providence Holy Cross Medical Center	$1,759,257
Ronald Reagan UCLA Medical Center	$ 503,534
St. Francis Medical Center	$ 234,658
Dignity Health-St. Mary Medical Center	$ 680,756
Total Patient Based Funding	**$8,187,958**

The above amounts for each hospital were determined based on each Non-County Trauma Hospital's share of the total value of the Fiscal Year (FY) 2023-24 indigent claims submitted by all the Non-County Trauma Hospitals to the County, net of any FY 2022-23 disallowed claims, multiplied by the total funding allocated for this category (which include Measure B, Maddy,

and Federal matching funds). The value of the indigent claims was computed by applying the emergency department (ED) visit or per diem rates described in the paragraph below. The final value of all the claims was adjusted upwards by an escalation factor of 60.03%, in order to fully distribute the entire funding available for this category. Payments to Non-County Trauma Hospitals listed in this section will be made directly by the County (inclusive of the Maddy Fund as defined below) and/or by the California Department of Health Care Services (CDHCS) as enhanced Medi-Cal payments to eligible private hospitals as set forth in this Exhibit.

$ 6,425	per emergency department visit and assessment. (No such fee will be paid if the patient is admitted to the hospital as an inpatient from the emergency department.)
$12,471	for the first inpatient day; and
$ 5,417	for the second inpatient day; and
$ 4,283	for the third inpatient day; and
$ 4,283	for the fourth inpatient day; and
$ 3,023	for each day thereafter.

Accordingly, the Patient-Based Allocations will be taken into account in the amounts that the County recommends be paid by CDHCS as enhanced Medi-Cal payments taking into account direct payments the County has made or will make to the hospitals for such allocations.

2. Maddy Fund

Certain funding known as “Maddy Emergency Medical Services Fund” (Maddy Fund) is available for hospital care rendered to Eligible Patients (as defined in I.B below) by the Non-County Trauma Hospitals. As described in I.D of this Exhibit, Contractor is required to submit a claim (an “Eligible Claim”) to the County for the hospital care rendered to Eligible Patients within the Contract Period. Based on claims for patient visits and days from July 1, 2023, to June 30, 2024, County will determine the Maddy Fund

payment amount for ED visits, and inpatient stays up to three (3) days, using the rates below plus an escalation adjustment factor of 60.03%, due to each hospital for this Contract Period. The amount of Maddy Fund payments is included in determining the total funding for the Patient/Hospital-Based Allocation amount.

$ 6,425	per emergency department visit and assessment. (No such fee will be paid if the patient is admitted to the hospital as an inpatient from the emergency department.)
$12,471	for the first inpatient day; and
$ 5,417	for the second inpatient day; and
$ 4,283	for the third inpatient day.

B. GENERAL CONDITIONS

Contractor shall provide Trauma Services, as defined below, to Eligible Patients. For purposes of this Exhibit, an "Eligible Patient" is a patient receiving Trauma Services from Contractor meeting the following criteria: (1) the Contractor believes that the patient is unable to pay for the Trauma Services so provided; (2) the patient has no third-party coverage, in part or in whole for the Trauma Services provided by Contractor and (3) the patient's annual income places the patient at or below 200% of the current year Federal Poverty Level (FPL).

For purposes of this Exhibit, "third-party coverage" or "third-party payers" includes but is not limited to commercial insurance or any program funded in whole or in part by local, state, or federal government. "Trauma Services" refers to all hospital services furnished by the Contractor to a patient who presents to the Contractor or is classified subsequently during the patient's stay as a Trauma Patient from the time the patient presents at or is admitted to the Contractor's hospital until the patient is discharged. The term "Trauma Patient" for purposes of this Contract is defined in the Specialty Care Center Designation Master Agreement Exhibit A, Sub Exhibit - TC Trauma Center, Attachment 5, *Patient Inclusion in the Trauma Data System* and incorporated in this Exhibit as Attachment 1.

A claim (a “Patient-Based Claim”) shall not be submitted to the County hereunder for an Eligible Patient if: (a) the patient has the ability to pay for the service but refuses or fails to pay for the service; or (b) Contractor has failed to submit to any known third-party payer(s) for the patient, an accurate, complete, and timely billing, and for that reason has been denied payment by such payer(s); or (c) for any Trauma Services which is covered in, or the subject of reimbursement in, any other contract between Contractor and County. Subject to the County’s review and verification, Contractor will determine and document persons who are Eligible Patients as described in Section I.C below.

County claim is accepted from Non-County Trauma Hospitals for patient care provided to Trauma Patients who do not have the ability to pay for the services under the following conditions: (1) Contractor has made a reasonable, good faith effort to determine if there is a responsible private or public third-party source of payment, in accordance with Section I.C below; (2) Contractor either determines that there is no source of payment; or there is a potential source of payment, but the Contractor is unable to obtain payment after making reasonable efforts to pursue such revenue and (3) the patient’s annual income places the patient at or below 200% of the current year Federal Poverty Level (FPL).

During the term of this Agreement, as required by Section 16818 of the Welfare and Institutions Code (W&IC), Contractor shall continue to provide, at the time treatment is sought by a patient at its facility, an individual notice of the availability of reduced cost hospital care. Additionally, Contractor shall post, in conspicuous places in its emergency department and patient waiting rooms, notices of the procedures for applying for reduced-cost hospital care. The approved “Notice” language is reflected in English in Attachment 2 and in Spanish in Attachment 3.

C. PATIENT ELIGIBILITY

For a patient to be an Eligible Patient, Contractor must document that the person cannot afford to pay for the services provided by the Contractor. Contractor must

also document that payment for the services will not be covered by third-party coverage, including any program funded in whole or in part by the federal government, and that Contractor has not received payment for any portion of the amount billed.

The documentation that the person cannot afford to pay must show that the patient's annual income places the patient at or below 200% of the current year's Federal Poverty Level (FPL).

Contractor shall utilize Attachment 4, *Trauma Service County Eligibility* ("TSCE") *Agreement* form as the sole means for determining whether the patient is at or below the 200% of the current year FPL and therefore meets patient's eligibility criteria for trauma care claiming during the term of this Agreement. The TSCE Agreement form must be completed and signed by the patient or the patient's responsible relative(s) at the time it is determined there is not a responsible private or public third-party source of payment and that the patient meets the eligibility requirements. The completed form must be signed and dated by the hospital representative who obtained the information, verifying that the information was obtained from the patient or the patient's responsible relative(s).

If a TSCE Agreement form cannot be secured because the patient's condition prevents the patient from providing the necessary financial information, and there is no responsible relative(s) available, then Attachment 5, *Hospital Certification of Inability to Cooperate* form must be completed. A hospital representative will complete the form, sign and date it, and a second hospital representative will verify the information by also signing and dating the form. The original (or electronic scan) of either the *TSCE* or *Inability to Cooperate* form must be maintained by Contractor as part of its financial records. Contractor shall submit a copy of the application form to the County Emergency Medical Services (EMS) Agency when submitting a claim to be included in the patient-based claims total as stated in Attachment 6, *Instructions for Submission of Claims and Data Collection*.

Contractor must document that it has made reasonable efforts to secure payment from the patient by billing upon discharge and two (2) subsequent billings at least a month apart with a minimum of three (3) billings. Financial notes must clearly indicate that the patient was billed at least three (3) times.

Documentation to establish that Contractor has complied with the aforementioned patient eligibility requirements must be maintained by Contractor and made available upon request to authorized County or State representatives for inspection, audit, and photocopying.

D. CLAIMS SUBMISSION

Contractor shall submit all Patient-based Claims to the County for Trauma Services to Eligible Patients for the Contract Period. These claims, subject to the following conditions and subsequent agreements of the parties, will be used to determine the amount of the patient-based Budget Allocation for Contractor. Claims from the prior fiscal year will be used to determine the patient-based funding for the contract period.

1. A valid claim shall include a completed Trauma Patient Summary ("TPS") form for each Eligible Patient receiving Trauma Services.
2. In addition to the TPS form, Contractor shall submit the required claim form (UB04) as well as all required reports as set forth in Attachment 6, *Instructions for Submission of Claims and Data Collection*, attached hereto and incorporated herein by reference, to County's Emergency Medical Services Agency, 10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, California 90670, for Trauma Services provided to Eligible Patients under the terms of this Agreement. This information shall be used in determining the next (and possibly subsequent) year's Budget Allocation.
3. Claims submitted to the County shall be limited to the hospital component of Trauma Services provided to Eligible Patients during the term of this Agreement. Inclusion of the claims in the determination of a Contractor's Budget Allocation or funding under

this Agreement shall be limited to the claims for which all required data has been included in the Trauma and Emergency Medicine Information System (TEMIS) and which has been submitted as required by reporting procedures reflected in Attachment 6.

4. Claims shall be submitted to County's EMS Agency on an ongoing basis once all eligibility requirements have been met and the Contractor has determined that no other source of funding is likely to be available. All Contractor claims for services provided during a County Fiscal Year (FY) (July 1 – June 30) must be received by County no later than the last working day of the first December following the close of the FY. Only claims for which the Contractor has ascertained that no payment will be received should be submitted.

5. To the extent permitted by law, upon submission of claim by Contractor to County for a trauma patient's care, and unless and until the claim is rejected by the County, Contractor assigns and subrogates to County any and all rights to collection as set forth herein, and Contractor shall cease all current and waive all future collection efforts, by itself and by its contractors/agents, to obtain any payment from the patient. At its sole discretion, County and/or County's Contractor may proceed independently against any parties responsible for payment for the Trauma Services to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement up to the full amount of usual and customary fees (including, for example, billed charges) for patient care and services regardless of any amount the Contractor has received under the TCPR, but only to the extent permitted by law. In the event Contractor is contacted by a third party's representative (e.g., insurance claim adjuster) or a patient's attorney regarding pending litigation concerning a claim that has been assigned to the County hereunder, Contractor shall indicate that the claim is assigned and subrogated to the County and refer

such representative to the designated County contact. Contractor shall reasonably cooperate with County in its collection efforts.

6. Contractor shall notify the County, and update the financial status of the patient in TEMIS, if Contractor becomes aware of any third-party coverage such as Medi-Cal, Medicare, other government programs**,** or other health insurance for any claim that the Contractor submitted to be included for purposes of calculating the Budget Allocation. The County has all rights to work with the identified third-party payers to receive any payment due with respect to claims that Contractor has assigned to County, but only to the extent permitted by law.

7. Any and all payments received by Contractor from a Trauma Patient or from third-party payers, including a legal settlement, for a claim previously submitted to and not rejected by the County, must be immediately reported to the County, and the payment amount shall be surrendered and remitted to the County since Contractor assigned and subrogated its rights to said claim. Contractor must remit to the County the payment that was received within sixty (60) days of receipt of such payment and must complete and submit Attachment 7, TRAUMA CENTER PAYMENT SURRENDER FORM, with each surrendered payment.

8. For Trauma Patients admitted to Contractor's facility prior to or on the last day during the term of this Agreement and remaining in the hospital after that date, reports and claim submission to County shall be made only after the patient has been discharged; the Contractor shall not submit partial or interim billings.

9. All reports and claims shall be completed in such detail and with such attachments as are in accordance with procedures prescribed in writing in Attachment 6. Contractor hereby acknowledges receipt of such forms, attachments, and procedures. Contractor and County agree that County may revise such forms, and such procedures and instructions without using a formal amendment to this Agreement. Such revised forms, procedures and instructions shall be effective at

least fifteen (15) calendar days after written notice to Contractor. In the event Contractor submits a timely written objection, Contractor and County will promptly meet and confer in good faith in an effort to resolve their differences. In the event the parties are not able to resolve their differences, Contractor may send a written notice to County within (30) days of the meet and confer session terminating this Agreement. This Agreement shall terminate fifteen (15) days after the date of the written notice, on such other days as the parties shall agree in writing.

E. AUDITING OF RECORDS

Contractor shall maintain and, upon request, make available to State or County representatives, records containing the financial information referenced in this Section, including records of patient and third-party payer payments, all in accordance with Section I B. General Conditions of this Exhibit.

1. County may periodically conduct an audit of the Contractor's records pertaining to the Patient-Based Claims for Eligible Patients that are required under this Exhibit. Audits shall be performed in accordance with generally accepted auditing standards. The audit may be conducted on a statistically random sample of submitted claims for a fiscal year, provided the sampling methodology is statistically valid. The scope of the audit shall include an examination of patient medical and financial records, patient and/or insurance billing records, and collection agency reports associated with the sampled claims.
2. Audited claims that do not comply with requirements in this Agreement shall result in a reduction in the total value of patient-based claims that will be used to determine each trauma hospital's patient-based Budget Allocation for the next fiscal year. For example, if two patient-based claims for the prior fiscal year with a total value of $12,850 were audited and determined not to be in compliance with the program requirements and the Contractor's total

value of submitted claims for that prior fiscal year was $150,000, $12,850 would be subtracted from the total value, reducing it to $137,150 which would then be the amount used to determine the Contractor's patient-based Budget Allocation for the next fiscal year. The County will notify Contractor of any audit findings. Audit results may be appealed to the EMS Agency Director, or his/her designee.

II. FUNDING FOR PEDIATRIC TRAUMA CENTERS

The parties acknowledge that Chapter 841 of the Statutes of 2006, authorized the County Board of Supervisors (Board), until December 31, 2008, to elect to levy an additional penalty in the amount of two dollars ($2) for every ten dollars ($10), upon fines, penalties, and forfeitures collected for specific criminal offenses. This authority was subsequently extended to December 31, 2013, by Chapter 288 of the Statutes of 2008. New legislation (SB 191) was chaptered October 5, 2013, and Section 76000.5 of the Government Code was amended extending these provisions through January 1, 2017. In 2016, legislation (SB 867) was again passed amending Section 76000.5 of the Government Code, extending these provisions through January 1, 2027.

The legislation further authorized the Board to utilize fifteen percent (15%) of the funds collected pursuant to the provisions of Health and Safety Code section 1797.98a, subdivision (e) (known as Richie's Fund) to provide funding to enhance pediatric trauma services by both publicly and privately owned and operated Pediatric Trauma Centers (PTCs) throughout the County.

The FY 2023-24 Richie's Fund collections available for FY 2024-25 allocation to the non-County PTCs and County PTCs are $841,080. This amount is allocated to PTCs for the expansion of pediatric trauma care services as follows:

Cedars-Sinai Medical Center	$ 40,180
Children's Hospital Los Angeles	$ 40,180

MemorialCare Long Beach Medical Center	$ 40,180
Dignity Health-Northridge Hospital Medical Center	$600,000
Ronald Reagan UCLA Medical Center	$ 40,180
Total	**$760,720**

III. DESIGNATION SUPPORT FUNDING

The funding described in this Section III is in addition to the funding described in Section I and II of this Exhibit.

A. BASE HOSPITAL SERVICES AND INFRASTRUCTURE

To account for the special costs incurred for those private trauma hospitals providing base and trauma hospital services and to ensure the continued access by Medi-Cal beneficiaries to emergency rooms and emergency room care in the County by maintaining efficient prehospital transport of all patients to the most appropriate emergency room, the County will recommend to the State that it make an aggregate supplemental payment in the amount of $700,000 for base station and $1,200,000 for infrastructure to each private Non-County Trauma Hospital pursuant to the Trauma SPA, with the exception of Children's Hospital Los Angeles. Children's Hospital Los Angeles will receive a supplemental infrastructure payment in the amount of $1,200,000 but will not receive a supplemental base station payment because it does not provide base hospital services.

As public hospitals, Ronald Reagan UCLA Medical Center ("UCLA") and Antelope Valley Hospital ("Antelope") may not receive these supplemental Medi-Cal payments under the State Plan. Accordingly, the County will directly pay each of those hospitals the amount of $700,000 for base station support and $1,200,000 for infrastructure support at or about the same time as County makes its IGT payment to the State. In the event the County makes its IGT payment to the State in multiple installments, the County will

make the base station and infrastructure supplemental payments to UCLA and Antelope in the same number of installments.

IV. ADD-ONS PAYMENTS

The funding described in this Section IV is in addition to the funding described in Sections I, II and III of this Exhibit. The total payment amounts below were designed to reflect the following: a) trauma patient volume; b) trauma patient acuity; and c) the levels of underinsured trauma patients treated.

Antelope Valley Hospital	$ 4,138,398
Dignity Health-California Hospital Medical Center	$ 6,556,813
Cedars-Sinai Medical Center	$ 4,546,528
Children's Hospital Los Angeles	$ 1,306,970
Henry Mayo Newhall Hospital	$ 1,737,043
Huntington Hospital	$ 3,291,122
MemorialCare Long Beach Medical Center	$ 4,492,982
Dignity Health-Northridge Hospital Medical Center	$ 4,300,688
Pomona Valley Hospital Medical Center	$ 4,290,588
Providence Holy Cross Medical Center	$ 3,888,630
Ronald Reagan UCLA Medical Center	$ 3,931,828
St. Francis Medical Center	$ 5,751,674
Dignity Health-St. Mary Medical Center	$ 3,157,694
Total	**$51,390,958**

Except for UCLA and Antelope, it is the intent of the County to send an IGT to CDHCS so it can draw down federal matching dollars for enhanced Medi-Cal payments to the above hospitals in the amounts set forth above. The County will issue the above payments directly to UCLA and Antelope as grants to support their provision of trauma services.

V. ADDITIONAL FUNDING FROM MEASURE B TAX RATE INCREASE

The funding described in this Section IV is in addition to the funding described in Sections I, II, III and IV of this Exhibit. On September 13, 2022, the Board of Supervisors approved an increase to the Measure B Trauma, Emergency, and Bioterrorism Response property assessment rate of $0.0076 per improved square foot, for a total assessment of $0.0500 per improved square foot, effective July 1, 2022. The additional revenue from the Measure B tax rate increase is projected to generate approximately $50.18 million annually. Of this revenue, the Board approved $5.96 million per year to thirteen (13) non-County Trauma Hospitals to support staffing, technology, and capital improvement investments to maintain or expand the regional trauma care system; as well as $3.00 million per year to five (5) non-County Pediatric Trauma Hospitals for investments in staffing, technology, and capital improvements to boost pediatric trauma care.

1. The additional payments to the thirteen (13) Non-County Trauma Hospitals are as follows:

Additional Funding To Support Trauma Care System	
Antelope Valley Hospital	$ 792,308
Dignity Health-California Hospital Medical Center	$ 1,367,082
Cedars-Sinai Medical Center	$ 821,274
Children's Hospital Los Angeles	$ 310,092
Henry Mayo Newhall Hospital	$ 462,666
Huntington Hospital	$ 647,114
MemorialCare Long Beach Medical Center	$ 804,602
Dignity Health-Northridge Hospital Medical Center	$ 907,290
Pomona Valley Hospital Medical Center	$ 823,102
Providence Holy Cross Medical Center	$ 933,614
Ronald Reagan UCLA Medical Center	$ 783,634
St. Francis Medical Center	$ 975,478
Dignity Health-St. Mary Medical Center	$ 709,802
Total	**$10,338,058**

The above total payment amount of $10.34 million includes Measure B funding and federal matching. Except for Antelope and UCLA, the County intends to send an IGT to CDHCS so it can draw down federal matching dollars for enhanced Medi-Cal payments to the above hospitals in the amounts set forth above. The County will issue the above payments directly to Antelope and UCLA.

2. The payments to the five (5) non-County Pediatric Trauma Hospitals are as follows:

Additional Funding To Support Pediatric Trauma Care	
Cedars-Sinai Medical Center	$ 340,958
Children's Hospital Los Angeles	$2,631,640
MemrialCare Long Beach Medical Center	$1,125,286
Dignity Health-Northridge Hospital Medical Center	$ 849,316
Ronald Reagan UCLA Medical Center	$ 526,400
Total	**$5,473,600**

The above total payment amount of $5.47 million includes Measure B funding and federal matching. Except for UCLA, the County intends to send an IGT to CDHCS so it can draw down federal matching dollars for enhanced Medi-Cal payments to the above hospitals in the amounts set forth above. The County will issue the above payments directly to UCLA.

VI. PAYMENT LIMIT

Contractor acknowledges that the amounts payable under Attachment A ("the Trauma SPA") are limited to the uncompensated costs of providing outpatient hospital services of all eligible private trauma hospitals in Los Angeles County and are also limited by the State's upper payment limit, as established in 42 C.F.R. Section 447.321. To the extent that either or both limits preclude the State from

paying all the aggregate amounts set forth below, the amount to be recommended by the County for each private trauma hospital shall be reduced by the same percentage as the percentage of total allowable supplemental payments under the Trauma SPA is to total recommended supplemental Medi-Cal payments under the Trauma SPA to all private trauma hospitals.

VII. POTENTIAL IGT FOR FEDERAL MATCHING FUNDS

As discussed in Section III, the County intends that the Designation Support payments, Add-On Payments, a portion of the Patient-Based payments and any Additional Payments Due to Measure B Rate Increase, should they be allocated, to the private Non-County Trauma Hospitals be made as additional Medi-Cal payments in accordance with the Trauma SPA. Unless CDHCS rejects this payment approach, the County will transfer the non-federal share of such funds to CDHCS in one or more IGTs. The amount of the additional Medi-Cal payments to the private Non-County Trauma Hospitals will be included in the amounts set forth in Sections IA.1, III, IV and V above.

The parties acknowledge and agree that some or all of the IGT, which the County intends to make to effectuate the provisions of this Agreement may not be capable of drawing down federal matching funds under the Trauma SPA. To the extent that is true, the parties agree that the County shall have no obligation to make an IGT of such amounts and shall instead provide such IGT funds directly to the private Non-County Trauma Hospitals in proportion to the payments that would have been made to each hospital relating to such IGT funds if the funds had been accepted as a permissible IGT for which federal matching funds would be available under the Trauma SPA. To the extent that Non-County Trauma Hospitals receive the full amounts set forth in Section VIII, County has no obligation to make further direct payments, even if not all of the funds set aside for use as an IGT are ultimately used for that purpose.

The total amount of the IGT the County intends to make shall be $41.35 million.

VIII. TOTAL MAXIMUM PAYMENTS

The total maximum payments that each Non-County Trauma Hospital may receive, either directly from the County, or from the State of California, as additional Medi-Cal payments under the Trauma SPA (which includes the amounts of IGTs made by the County and federal matching funds), and subject to the limitations and conditions as described in this Agreement, shall be as follows:

Antelope Valley Hospital	$ 7,197,796
Dignity Health-California Hospital Medical Center	$ 12,419,374
Cedars-Sinai Medical Center	$ 7,842,071
Children's Hospital Los Angeles	$ 5,488,882
Henry Mayo Newhall Hospital	$ 4,203,126
Huntington Hospital	$ 5,878,757
MemorialCare Long Beach Medical Center	$ 8,474,935
Dignity Health-Northridge Hospital Medical Center	$ 9,691,674
Pomona Valley Hospital Medical Center	$ 7,477,540
Providence Holy Cross Medical Center	$ 8,481,501
Ronald Reagan UCLA Medical Center	$ 7,685,576
St. Francis Medical Center	$ 8,861,810
Dignity Health-St. Mary Medical Center	$ 6,448,252
Total	**$100,151,294**

Each non-County Trauma Hospital will be paid the above amounts through a combination of direct payments by the County or additional Medi-Cal payments under the Trauma SPA, except for UCLA and Antelope, which shall receive only funds from the County. Payments may be reduced to the extent that the amounts anticipated to be paid as Medi-Cal funds through the Trauma SPA cannot be paid in that manner, in which case the County will make direct payments of the non-federal share of such payments, up to, but not exceeding the amount of the IGT set forth above, less the amount used to fund the Medi-Cal payments which were actually made.

IX. EFFECTIVE DATES

The provisions of this Exhibit shall only apply to trauma services provided on or after July 1, 2024 and before July 1, 2025.

LISTING OF ATTACHMENTS

ATTACHMENT	ATTACHMENT NAME
1.	PATIENT INCLUSION IN THE TRAUMA CENTER DATA SYSTEM
2.	HOSPITAL SIGNAGE – NOTICE OF REDUCED COST CARE-ENGLISH
3.	HOSPITAL SIGNAGE – NOTICE OF REDUCED COST CARE- SPANISH
4.	TRAUMA SERVICE COUNTY ELIGIBILITY (TSCE)
5.	HOSPITAL CERTIFICATION OF INABILITY TO COOPERATE
6-6.8	INSTRUCTIONS FOR SUBMISSION OF TRAUMA CLAIMS AND DATA COLLECTION
7.	TRAUMA CENTER PAYMENT SURRENDER FORM

LOS ANGELES COUNTY TRAUMA DATABASE INCLUSION CRITERIA

TRAUMA CENTER SERVICE AGREEMENT

PATIENT INCLUSION IN THE TRAUMA DATA SYSTEM

EXCLUSIONS:

Patients with the following injuries are to be EXCLUDED from the registry, unless an additional injury that meets criteria/guidelines exists:

GROUND LEVEL FALLS:

resulting in isolated closed hip fractures in patients > 50 years of age; or
ALL injuries of or distal to the knee or elbow in patients of any age

OR

drownings; hangings; poisonings; late effect of injuries; foreign bodies; superficial injuries (S00, S10, S20, S30, S40, S50, S60, S70, S80, & S90); insect bites; isolated injuries to fingers and/or toes; and injury codes that do not generate an ISS.

INCLUSIONS:

Does the patient have at least one ICD-10 injury diagnostic code within the range of S00 - S99; T20-T28; T30-T32; & T79.A1 - T79.A9?

HOSPITAL ADMISSION?

Was the patient admitted for care of an injury after ED evaluation by the Trauma Surgeon?

OR

Was the patient transferred to or from your facility, and admitted by a Trauma Surgeon for care of an injury?

No

DEATH?

Did the patient die of an injury-related problem?

No

DID THE PATIENT ARRIVE VIA EMS?

Yes

PREHOSPITAL DECISION?

Did the patient meet Trauma Triage Criteria, Guidelines, or Special Considerations per Reference 506?

No

Patient DOES NOT meet inclusion criteria

No

TRAUMA CRITERIA?

Did the NON-EMS patient meet Trauma Triage Physiological & / or Anatomical Criteria per Reference 506.1?

(Mechanism of Injury Criteria, Guidelines, and Special Considerations are NOT applicable for non-EMS patients)

Yes

Yes

Yes

Yes

Yes

Patient MEETS inclusion criteria

CASES ENTERED INTO THE REGISTRY THAT DO NOT MEET THE INCLUSION CRITERIA MUST BE IDENTIFIED AS "DHS=NO", AND HAVE THE TPS RATIONALE OF "DHS=NO" INDICATED.

January 1, 2021 (Implemented)
Validunt II amended by the EMS Agency
(Replaces Exhibit C dated January 1, 2020)

NOTICE

MEDICAL CARE FOR THOSE WHO CANNOT AFFORD TO PAY

THIS HEALTH CARE FACILITY PROVIDES SERVICES FREE OF CHARGE OR AT A REDUCED CHARGE TO PERSONS WHO CANNOT AFFORD TO PAY FOR MEDICAL CARE.

IF YOU ARE UNABLE TO PAY FOR ALL OR PART OF THE CARE YOU NEED, YOU MAY CONTACT THE ADMISSIONS OR BUSINESS OFFICE OF THIS FACILITY AND ASK ABOUT THE AVAILABILITY OF SUCH CARE. IF YOU WOULD LIKE FURTHER INFORMATION, YOU MAY CALL THE COUNTY OF LOS ANGELES, PRIVATE SECTOR COORDINATOR'S OFFICE AT (562) 378-1590.

NOTICIA

SERVICIO MEDICO PARA QUIENES NO PUEDEN AFRONTAR PAGARLO

ESTE HOSPITAL PROVEE SERVICIOS GRATIS O A COSTO REDUCIDO A PERSONAS QUE NO PUEDEN PAGAR POR SERVICIOS MEDICOS.

SI USTED NO PUEDE PAGAR POR TODO O PARTE DEL CUIDADO QUE NECESITA, USTED DEBE COMUNICARSE CON LA OFICINA DE ADMISIONES O NEGOCIOS DE ESTE HOSPITAL Y PREGUNTAR ACERCA DE ESTE PROGRAMA. SI DESEA MAS INFORMACION, PUEDE LLAMAR AL CONDADO DE LOS ANGELES, OFICINA DEL COORDINADOR DEL SECTOR PRIVADO, AL (562) 378-1590.

TRAUMA SERVICE COUNTY ELIGIBILITY (TSCE) AGREEMENT

Trauma Service Hospital/Physician _____ Medical Record Number _____ Date(s) of Service _____/_____/_____

NOTE: Patients unwilling or refusing to cooperate DO NOT qualify for the Trauma Services for Indigents Program.

PATIENT INFORMATION:

Last _____ First _____ Middle _____

Street _____ City _____ State _____ Zip _____

Social Security Number _____-_____-_____ Telephone Number ( )_____-_____ Birth Date _____/_____/_____

Patient's Responsible Relative(s) Name(s) Addresses(s) _____

Does patient have third party coverage (i.e., private insurance) which may partially or fully cover the cost of health services on the above date(s)?

YES ☐ (IF YES, PATIENT IS NOT ELIGIBLE) NO ☐

TSCE ELIGIBILITY COMPUTATION: (Taken from 2025 Federal Poverty Level 4/1/25)

CIRCLE ONE IN EACH COLUMN BELOW: Figure Family Size based on the number of persons in the patient's household. Figure the income of the patient and the patient's responsible relative(s) before taxes and deductions.

Family Size	Monthly Income	Yearly Income
1	$2,610	$31,300
2	3,526	42,300
3	4,442	53,300
4	5,360	64,300
5	6,276	75,300
6	7,192	86,300
7	8,110	97,300
8	9,026	108,300
9	9,942	119,300
10	10,860	130,300
11	11,776	141,300
12	$12,692	$152,300

(For family units with more than 12 members, add $918 monthly and $11,000 yearly for each additional member.)

My/our Monthly Income and Yearly Income are less than or equal to the amount circled above.

TSCE CERTIFICATION:

I/we understand that in order to be eligible for TSCE for the health services received on the above date(s), my/our Monthly Income and Yearly Income must be less than or equal to the amounts corresponding to my/our Family Size. I/we will not be liable for these health services.

I/we understand and agree that this Agreement shall be governed by the terms and conditions set forth in the TSCE, which has been made available to me/us for review, and that I/we shall fully cooperate with the County and Trauma Service Hospital in accordance with the TSCE.

I/WE, PATIENT OR RESPONSIBLE RELATIVE(S), CERTIFY UNDER PENALTY OF PERJURY BY MY/OUR SIGNATURE(S) THAT THE INFORMATION I/WE HAVE GIVEN TO DETERMINE MY/OUR TRAUMA SERVICE COUNTY ELIGIBILITY AS CIRCLED ABOVE FOR HEALTH SERVICES ON THE ABOVE DATE(S) IS TRUE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF. I/WE ALSO CERTIFY THAT I/WE HAVE DISCLOSED ALL MY/OUR THIRD PARTY COVERAGE WHICH MAY PAY FOR ANY OF THE COST OF HEALTH SERVICES RECEIVED. I/WE UNDERSTAND THAT IF I/WE HAVE A THIRD OR FIRST PARTY CLAIM OR LAWSUIT, LOS ANGELES COUNTY EMERGENCY MEDICAL SERVICES, SHALL HAVE THE RIGHT TO RECOVER ALL REASONABLE HOSPITAL AND PHYSICIAN CHARGES INCURRED DURING THE ABOVE REFERENCED DATE OF SERVICE AND OTHER MEDICAL SERVICES RELATED HERETO AS PERMITTED BY STATE LAW. THIS INCLUDES THE FULL BILLED CHARGES OF THE HOSPITAL.

Patient's Signature _____ Date _____/_____/_____

Responsible Relative(s) Signature _____ (State relationship to patient) _____ Date _____/_____/_____
If patient unable to sign

TSCE Hospital Reviewer (Required to verify above information and signature) _____ Date _____/_____/_____

THIS FORM OR A U-2 MUST BE ON FILE IN THE PATIENT(S) FINANCIAL CHART

ATTACHMENT 5

HOSPITAL CERTIFICATION OF INABILITY TO COOPERATE (U-2) AGREEMENT

_____ _____ _____
Trauma Service Hospital/Physician Medical Record Number Date(s) of Service

NOTE: Patients **unwilling or refusing to cooperate** DO NOT qualify for the Trauma Services for Indigents Program.

PATIENT INFORMATION:

_____
Last First Middle

_____
Street City State Zip

_____
Patient's Responsible Relative(s) Name(s) Addresses(s)

_____-_____-_____ ( ) _____-_____ _____/_____/_____
Social Security Number Telephone Number Birth date

WE CERTIFY UNDER PENALTY OF PERJURY BY OUR SIGNATURES THAT WE HAVE USED ALL REASONABLE MEANS TO DETERMINE THE PATIENT'S ELIGIBILITY IN ACCORDANCE WITH THE TSCE AGREEMENT. SPECIFICALLY, WE HAVE USED ALL REASONABLE MEANS TO:

1) Obtain the names and addresses of the patient and the patient's responsible relatives,

2) Obtain acceptable address verification, and

3) Obtain all information needed to complete the TSCE Agreement, including information regarding the income and family size of the patient and patient's responsible relatives, and the patient's third-party coverage.

The patient and/or patient's responsible relatives, if any, were UNABLE to cooperate fully because:

_____

and TO THE BEST OF OUR KNOWLEDGE AND BELIEF, THE PATIENT OR PATIENT'S RESPONSIBLE RELATIVES ARE UNABLE TO PAY FOR THE COST OF HEALTH SERVICES PROVIDED AND THEPATIENT OR PATIENT'S RESPONSIBLE RELATIVES HAVE NO THIRD-PARTY COVERAGE FOR THESE HEALTH SERVICES. THE INFORMATION SET FORTH ABOVE IS ALL OF THE INFORMATION WEWERE ABLE TO OBTAIN WITH RESPECT TO THIS PATIENT.

_____ _____/_____/_____
Hospital Reviewer #1 Date

_____ _____/_____/_____
Hospital Reviewer #2 Date

THIS FORM MUST BE SIGNED BY TWO HOSPITAL STAFF VERIFYING THE REASON THE PATIENT AND/OR THE PATIENT'S RESPOPNSIBLE RELATIVES, IF ANY, WERE UNABLE TO COOPERATE AND SHOULD BE COMPLETED AT THE TIME OF REGISTRATION AND FINANCIAL INFORMATION IS COLLECTED FOR THIS ACCOUNT.

THIS FORM OR A TSCE MUST BE ON FILE IN THE PATIENT'S FINANCIAL CHART

Instructions for Submission of Trauma Claims and Data Collection

COUNTY OF LOS ANGELES•DEPARTMENT OF HEALTH SERVICES

NON-COUNTY HOSPITALS

INSTRUCTIONS FOR SUBMISSION OF TRAUMA CLAIMS AND DATA COLLECTION

GENERAL INFORMATION

Hospitals must submit a **UB-04 Form,** a copy of the **Trauma Service County Eligibility (TSCE)**, or a copy of the **Hospital Certification of Inability to Cooperate** and a copy of the **Tobacco Tax Combo Print-out** for each eligible patient's care if they want an indigent patient claim to be considered in the formula for Trauma Center funds. Additionally, Hospitals must submit an **Excel Electronic File of the UB 04 Data** with the paper copy of the claim packet. If Hospital is unable to submit an electronic file of the UB-04, they must submit the required UB-04 data in an Excel or CSV file and submit an electronic copy of this file when claims are submitted.

PATIENT INFORMATION: Hospitals are required to make reasonable efforts to collect all information as required on the TSCE form. If, after reasonable efforts are made, some data elements cannot be obtained for services provided as EMERGENCY DEPARTMENT, indicate "N/A" (not available) in the space for the data element which was not obtainable. **Claims for services provided to patients shall not be accepted without completion of all data elements unless a reasonable justification is provided, e.g., "comatose on arrival and expired with no family or identification".** In these cases, a **Hospital Certification of Inability to Cooperate** should be submitted.

In addition to the above claims submission requirements, if a refund is received by Contractor from a Trauma Patient or from third-party payers, including a legal settlement, for a claim previously submitted to the County, this must be immediately reported to the County and the payment amount shall be surrendered and remitted to the County since Contractor assigned and subrogated its rights to said claim. Contractor must remit to the County the payment it received within sixty (60) days of receipt of such payment and must complete and submit a **TRAUMA CENTER PAYMENT SURRENDER FORM** with each surrendered payment.

HOSPITALS–SUBMIT CLAIMS TO:
Department of Health Services
Emergency Medical Services (EMS) Agency
10100 Pioneer Blvd., Suite 200
Santa Fe Springs, CA 90670
Attention: HOSPITAL CLAIMS
Contact: Hospital Reimbursement Coordinator – (562) 378-1590

COUNTY OF LOS ANGELES•DEPARTMENT OF HEALTH SERVICES

NON-COUNTY HOSPITALS

INSTRUCTIONS FOR COMPLETION OF THE UB-04 FORM

The following fields on the UB -04 must be completed:

1 HOSPITAL
Hospital name and address

3a PATIENT CONTROL NUMBER
Unique patient identification number assigned by provider to retrieve individual accounts

3b. MEDICAL RECORD NUMBER
Patient's Medical Record Number

4 TYPE OF BILL
0111 for Inpatient claims or 0131 for Outpatient claims

6 STATEMENT COVERS PERIOD
FROM = **Admit date** THROUGH **= Discharge date**

8b PATIENT NAME
Patient's last, first name and middle initial

9a-d. PATIENT'S ADDRESS
Patient's full address

10 BIRTH DATE
Patient's date of birth

11 SEX
Patient's gender

42 REVENUE CODE
The appropriate numeric code to identify specific accommodations and/or ancillary services in ascending numeric order, by date of service if appropriate (i.e. **209 ICU**).

44 HCPCS CODE OR CPT CODE
The CPT-4 code set (Current Procedural Terminology, 4th Edition Fill from the left-most position (i.e. **99291**)

46 SERVICE Units
Length of Stay

INSTRUCTIONS FOR COMPLETION OF THE UB-04 FORM

47 TOTAL
Total charges

56. NATIONAL PROVIDER IDENTIFIER
The hospitals unique ten-digit NPI identification number

57 FACILITY ID NUMBER
The hospitals unique six-digit OSHPD number

60 INSURED'S UNIQUE IDENTIFIER
The Trauma Patient Sequence (TPS) number

67 PRINCIPAL DIAGNOSIS
The complete ICD-10 CM diagnosis code that describes the principal diagnosis or the chief reason for performing a service on an outpatient basis

67a-q OTHER Dx CODES
The complete ICD-10-CM diagnosis codes for up to 17 additional conditions, **if applicable**

74. PRINCIPAL PROCEDURE CODE AND DATE
The ICD code that identifies the principal procedure and the date of those procedures, **if applicable**

74 a-e OTHER PROCEDURES DESCRIPTIONS
Other ICD codes identifying all significant procedures performed. **if applicable**

COUNTY OF LOS ANGELES•DEPARTMENT OF HEALTH SERVICES

NON-COUNTY HOSPITALS

INSTRUCTIONS FOR COMPLETION OF THE TRAUMA SERVICE COUNTY ELIGIBILITY (TSCE)

GENERAL INFORMATION

Hospitals must submit a copy of the completed and signed **Trauma Service County Eligibility (TSCE)** for each eligible patient's care. if they are claiming reimbursement for Trauma Hospital funds.

The TSCE shall be utilized by Contractor as the sole means for determining each patient's eligibility for trauma care coverage during the term of this Agreement. The TSCE must be completed and signed by the patient or the patient's responsible relative(s).

NOTE: If a TSCE cannot be secured because the patient or the patient's responsible relative (s) is (are) unable to cooperate to that effect, a Hospital Certification of Inability to Cooperate must be completed.

Patients unwilling or refusing to cooperate DO NOT qualify for the Trauma Services for Indigents Program.

PATIENT INFORMATION: Hospitals are required to make reasonable efforts to collect all data elements on the following questions:

- 3rd party coverage question
- Family size/income
- Signature (by patient or responsible relative only)
- Obtain signature of Hospital Reviewer/Translator who obtained information and explained program to patient at the time it is determined that eligibility requirements have been met.

TRAUMA SERVICE HOSPITAL/PHYSICIAN
Enter Trauma Hospital where services where provided

MEDICAL RECORD NUMBER
Enter Medical Record Number

DATES OF SERVICE
Enter month, day, and year of service

PATIENT INFORMATION
Enter patient's last name
Enter first name
Enter middle initial

PATIENT'S ADDRESS
Enter patient's street address
Enter city
Enter state
Enter zip code

INSTRUCTIONS FOR COMPLETION OF THE TRAUMA SERVICE COUNTY ELIGIBILITY (TSCE)

SOCIAL SECURITY
Enter patient's social security number

TELEPHONE NUMBER
Enter patient's area code and telephone number

BIRTHDATE
Enter patient's date of birth

PATIENT'S RESPONSIBLE RELATIVE(S) NAME
Enter name of patient's Responsible Relative (s) (only If patient is unable to sign)
Enter full address of Responsible Relative(s)
Key Points: Responsible relative means any relative of the patient that can obtain all information needed to complete the TSCE Agreement, including information regarding the patient's income, family size, and the patient's third-party coverage (if any)

TPL QUESTION
Check appropriate box to indicate if patient has third party coverage.
Key Points: Ensure that the Yes or No box is checked.

CIRCLE ONE IN EACH COLUMN BELOW

FAMILY SIZE
Circle the number of individuals related by birth, marriage, or adoption who usually share the same place of residence.

MONTHLY INCOME
Circle the appropriate total of patient's or patient's family's primary wage earner's wages and salaries.
Key Points: Write in the patient's monthly income if the total is less than what is indicated on the form.

YEARLY INCOME
Circle the appropriate total of patient's or patient's family's primary wage earner yearly income.
Key Points: Write in the patient's yearly income if the total is less than what is indicated on the form.

CIRCLE ONE IN EACH COLUMN BELOW

For family units with more than 12 members, add $918 monthly and $11,000 yearly for each additional member.)

PATIENT'S SIGNATURE AND DATE
Signature of patient
Enter date
Key Points: Ensure that patient completes, signs and dates the form at the time it is determined that eligibility requirements have been met.

Note: The patient's Responsible Relative should not sign in this section

INSTRUCTIONS FOR COMPLETION OF THE TRAUMA SERVICE COUNTY ELIGIBILITY (TSCE)

RESPONSIBLE RELATIVE SIGNATURE AND DATE

Responsible Relative(s) Signature (only if patient is unable to sign)
Enter the relationship to patient
Enter date

Key Points: Ensure that the patient's Responsible Relative completes, signs and dates the form at the time it is determined that eligibility requirements have been met. Include the relationship of the Responsible Relative to the patient.

TSCE HOSPITAL REVIEWER SIGNATURE AND DATE

Hospital Reviewer's Signature
Signature of translator who obtained information and explained program to patient)
Enter date

Key Points: Ensure that the Hospital Reviewer signs and dates the form at the time it is determined that eligibility requirements have been met. This form or a Hospital Certification of Inability to Cooperate must be on file in the patient's financial chart.

TRAUMA SERVICE COUNTY ELIGIBILITY (TSCE)

Trauma Service Hospital/Physician _____ Medical Record Number _____ Date(s) of Service ____/____/____

NOTE: Patients unwilling or refusing to cooperate DO NOT qualify for the Trauma Services for Indigents Program.

PATIENT INFORMATION:

Last _____ First _____ Middle _____

Street _____ City _____ State _____ Zip _____

Social Security Number ___-___-___ Telephone Number (___)___-____ Birth Date ____/____/____

Patient's Responsible Relative(s) Name(s) _____ Addresses(s) _____

Does patient have third party coverage (i.e., private insurance) which may partially or fully cover the cost of health services on the above date(s)?

YES ☐ (IF YES, PATIENT IS NOT ELIGIBLE) NO ☐

TSCE ELIGIBILITY COMPUTATION: (Taken from 2025 Federal Poverty Level 4/1/25)

CIRCLE ONE IN EACH COLUMN BELOW: Figure Family Size based on the number of persons in the patient's household. Figure the income of the patient and the patient's responsible relative(s) before taxes and deductions.

Family Size	Monthly Income	Yearly Income
1	$2,610	$31,300
2	3,526	42,300
3	4,442	53,300
4	5,360	64,300
5	6,276	75,300
6	7,192	86,300
7	8,110	97,300
8	9,026	108,300
9	9,942	119,300
10	10,860	130,300
11	11,776	141,300
12	$12,692	$152,300

(For family units with more than 12 members, add $918 monthly and $11,000 yearly for each additional member.)
My/our Monthly Income and Yearly Income are less than or equal to the amount circled above.

TSCE CERTIFICATION:

I/we understand that in order to be eligible for TSCE for the health services received on the above date(s), my/our Monthly Income and Yearly Income must be less than or equal to the amounts corresponding to my/our Family Size. I/we will not be liable for these health services.
I/we understand and agree that this Agreement shall be governed by the terms and conditions set forth in the TSCE, which has been made available to me/us for review, and that I/we shall fully cooperate with the County and Trauma Service Hospital in accordance with the TSCE.

I/WE, PATIENT OR RESPONSIBLE RELATIVE(S), CERTIFY UNDER PENALTY OF PERJURY BY MY/OUR SIGNATURE(S) THAT THE INFORMATION I/WE HAVE GIVEN TO DETERMINE MY/OUR TRAUMA SERVICE COUNTY ELIGIBILITY AS CIRCLED ABOVE FOR HEALTH SERVICES ON THE ABOVE DATE(S) IS TRUE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF. I/WE ALSO CERTIFY THAT I/WE HAVE DISCLOSED ALL MY/OUR THIRD-PARTY COVERAGE WHICH MAY PAY FOR ANY OF THE COST OF HEALTH SERVICES RECEIVED. I/WE UNDERSTAND THAT IF I/WE HAVE A THIRD-OR FIRST-PARTY CLAIM OR LAWSUIT, LOS ANGELES COUNTY EMERGENCY MEDICAL SERVICES, SHALL HAVE THE RIGHT TO RECOVER ALL REASONABLE HOSPITAL AND PHYSICIAN CHARGES INCURRED DURING THE ABOVE REFERENCED DATE OF SERVICE AND OTHER MEDICAL SERVICES RELATED HERETO AS PERMITTED BY STATE LAW. THIS INCLUDES THE FULL BILLED CHARGES OF THE HOSPITAL.

Patient's Signature _____ Date ____/____/____

Responsible Relative(s) Signature _____ (State relationship to patient) _____ Date ____/____/____
If patient unable to sign

TSCE Hospital Reviewer (Required to verify above information and signature) _____ Date ____/____/____

THIS FORM OR A U-2 MUST BE ON FILE IN THE PATIENT(S) FINANCIAL CHART

COUNTY OF LOS ANGELES•DEPARTMENT OF HEALTH SERVICES

NON-COUNTY HOSPITALS

INSTRUCTIONS FOR COMPLETION OF THE HOSPITAL CERTIFICATION OF INABILITY TO COOPERATE

GENERAL INFORMATION

If a Trauma Service County Eligibility (TSCE) cannot be secured because the patient or the patient's responsible relative (s) (are) unable to cooperate to that effect, hospital must submit a copy of the completed and signed Attachment **'Hospital Certification of Inability to Cooperate** for each eligible patient's care if they are claiming reimbursement for Trauma Hospital funds.

NOTE: Patients **unwilling or refusing to cooperate** DO NOT qualify for this program.

Do not use this form because TSCE form was mailed out and not completed nor returned by patient.

This form or a Trauma Service County Eligibility (TSCE) must be on file in the patient's financial chart.

1. TRAUMA SERVICE HOSPITAL/PHYSICIAN
   Enter Trauma Hospital where services where provided

2. MEDICAL RECORD NUMBER
   Enter Patient's Medical Record Number

3. DATE OF SERVICE
   Enter month, day, and year of service

4-6 PATIENT INFORMATION
   Enter patient's last name
   Enter first name
   Enter middle initial

7-10 PATIENT'S ADDRESS
   Enter patient's street address
   Enter city
   Enter state
   Enter zip code

11-12 PATIENT'S RESPONSIBLE RELATIVE(S) NAME
   Enter name of patient's Responsible Relative (s) (only If patient is unable to sign)
   Enter full address of patient's Responsible Relative(s)

13. SOCIAL SECURITY NUMBER
   Enter patient's Social Security Number

14. TELEPHONE NUMBER
   Enter patient's area code with telephone number

INSTRUCTIONS FOR COMPLETION OF THE HOSPITAL CERTIFICATION OF INABILITY TO COOPERATE

15. BIRTHDATE
Enter patient's birth date

16. REASON PATIENT UNABLE TO SIGN
Explain why the patient was unable to sign
Key Points: Indicate the patient's medical condition

Note: If patient walks out of the facility, refuses, or is unwilling to sign the form, this claim will not be eligible for payment

17. HOSPITAL REVIEWER #1
Signature of Hospital Reviewer/Translator who obtained information

18. DATE
Signature and date should be at the time of patient registration
Key Points: Ensure that the Hospital Reviewer signs and dates the form at the time it is determined that eligibility requirements have been met.

19. HOSPITAL REVIEWER #2
Signature of Hospital Reviewer's Supervisor and date

20. DATE
Date supervisor signed

This form or a Trauma Service County Eligibility (TSCE) must be on file in the patient's financial chart.

HOSPITAL CERTIFICATION OF INABILITY TO COOPERATE

Trauma Service Hospital/Physician _____ Medical Record Number _____ Date(s) of Service _____

NOTE: Patients **unwilling or refusing to cooperate** DO NOT qualify for the Trauma Services for Indigents Program.

PATIENT INFORMATION:

Last _____ First _____ Middle _____

Street _____ City _____ State _____ Zip _____

Patient's Responsible Relative(s) Name(s) _____ Addresses(s) _____

_____-_____-_____ Social Security Number

( ) _____-_____ Telephone Number

_____/_____/_____ Birth date

WE CERTIFY UNDER PENALTY OF PERJURY BY OUR SIGNATURES THAT WE HAVE USED ALL

REASONABLE MEANS TO DETERMINE THE PATIENT'S ELIGIBILITY IN ACCORDANCE WITH THE TSCE AGREEMENT. SPECIFICALLY, WE HAVE USED ALL REASONABLE MEANS TO:

1) Obtain the names and addresses of the patient and the patient's responsible relatives,

2) Obtain acceptable address verification, and

3) Obtain all information needed to complete the TSCE Agreement, including information regarding the income and family size of the patient and patient's responsible relatives, and the patient's third-party coverage.

The patient and/or patient's responsible relatives, if any, were UNABLE to cooperate fully because:

_____

and TO THE BEST OF OUR KNOWLEDGE AND BELIEF, THE PATIENT OR PATIENT'S RESPONSIBLE RELATIVES ARE UNABLE TO PAY FOR THE COST OF HEALTH SERVICES PROVIDED AND THEPATIENT OR PATIENT'S RESPONSIBLE RELATIVES HAVE NO THIRD- PARTY COVERAGE FOR THESE HEALTH SERVICES. THE INFORMATION SET FORTH ABOVE IS ALL OF THE INFORMATION WEWERE ABLE TO OBTAIN WITH RESPECT TO THIS PATIENT.

_____ _____/_____/_____

Hospital Reviewer #1 Date

_____ _____/_____/_____

Hospital Reviewer #2 Date

THIS FORM MUST BE SIGNED BY TWO HOSPITAL STAFF VERIFYING THE REASON THE PATIENT AND/OR THE PATIENT'S RESPOPNSIBLE RELATIVES, IF ANY, WERE UNABLE TO COOPERATE AND SHOULD BE COMPLETED AT THE TIME OF REGISTRATION AND FINANCIAL INFORMATION IS COLLECTED FOR THIS ACCOUNT.

THIS FORM OR A TSCE MUST BE ON FILE IN THE PATIENT'S FINANCIAL CHART

Trauma Center Provisions for Reimbursement MOA-Exhibit A

Revised 2/18/25

COUNTY OF LOS ANGELES•DEPARTMENT OF HEALTH SERVICES

NON-COUNTY HOSPITALS

INSTRUCTIONS FOR SUBMISSION OF THE TOBACCO TAX COMBO PRINT-OUT

GENERAL INFORMATION

The **Tobacco Tax Combo print-out** submitted with the claim is used to verify that the required trauma center's data is in the Trauma Emergency Medical Indigent Service (TEMIS) database. Hospitals must ensure that all like data elements in the TEMIS database match the UB-04 data for trauma patients.

The Tobacco Tax Combo print-out information from the EMS Agency's database, the print-out submitted from the hospital and data from the UB-04 must match. Only patients identified in TEMIS as "County Indigent" will be considered eligible for inclusion in the County's payment methodology to Trauma Centers.

VALIDATION OF TOBACCO TAX COMBO PRINT-OUT

Data to Be Validated	Line # on Print-out	Box # on UB 04	Validation Requirement
DHS Patient?	2	N/A	Must indicate DHS Y
Name	6	8b	Patient's last and first name must be correctly spelled
Adm Date	23	6 from	Admit date must match
D/C Date	24	6 through	Discharge date must match
Service Setting	28	4	ED or Ward
Payor 1	31	N/A	Must indicate County Indigent
Charges	33	47	Total Charges must match
Medical Record #	38	3b	Medical Record # must match
Date of Birth	39	10	DOB must match

LA County DHS TOBACCO TAX COMBO PRINT-OUT

Trauma Center	HCH
DHS Patient?	Y ←Line #2
Acct #	123456789
TPS #	CI12345678912
SS#	123-45-6789
Name	DOE, JOHN ←Line #6
Parent Last	*BL
Parent First	*BL
Birth City	COLUMBIA
Birth State	South Carolina
Birth Country	UNITED STATES
Mdn Name	BARKER
Race	White
Empl Typ	Unemployed
Mo Inc	1,500
Fam#	4
Source	Wages
Date Arr in ED	10/28/2020
Time Arr in ED	00:49
Date out ED	10/28/2020
Time out ED	05:26
ED TO:	WARD
Adm date	10/28/2020 ←Line #23
D/C Date	10/30/2020 ←Line #24
DC Time	14:54
Hosp D/C TO	*N/A
D/C To	HOME W/O
D/C From	WARD ←Line #28
LOS	3
L/D	L
Payor 1	COUNTY INDIGENT ←Line #31
Payor 2	*BL
Charges	113030.52 ←Line #33
St#	1313
Street	MOCKING BIRD LANE
City	ANY TOWN
ZIP	99999
MR#	12345678 ←Line #38
DOB	3/16/1990 ←Line #39
Age	30 Y
ICD-10 1	S35.8X1A
ICD-10 2	S36.539A
ICD-10 3	S36.439A
ICD-10 4	S31.611A
Procedure 1	06HN33Z
Procedure 2	30233N1

HOSPITAL'S TOBACCO TAX COMBO PRINT-OUT

Trauma Center	HCH
DHS Patient?	Y ←Line #2
Acct #	123456789
TPS #	CI12345678912
SS#	123-45-6789
Name	DOE, JOHN← ←Line #6
Parent Last	*BL
Parent First	*BL
Birth City	COLUMBIA
Birth State	South Carolina
Birth Country	UNITED STATES
Mdn Name	BARKER
Race	White
Empl Typ	Unemployed
Mo Inc	1,500
Fam#	4
Source	Wages
Date Arr in ED	10/28/2020
Time Arr in ED	00:49
Date out ED	10/28/2020
Time out ED	05:26
ED TO:	WARD
Adm date	10/28/2020 ←Line #23
D/C Date	10/30/2020 ←Line #24
DC Time	14:54
Hosp D/C TO	*N/A
D/C To	HOME W/O
D/C From	WARD ←Line #28
LOS	3
L/D	L
Payor 1	COUNTY INDIGENT ←Line #31
Payor 2	*BL
Charges	113030.52 ←Line #33
St#	1313
Street	MOCKING BIRD LANE
City	ANY TOWN
ZIP	99999
MR#	12345678 ←Line #38
DOB	3/16/1990 ←Line #39
Age	30 Y
ICD-10 1	S35.8X1A
ICD-10 2	S36.539A
ICD-10 3	S36.439A
ICD-10 4	S31.611A
Procedure 1	06HN33Z
Procedure 2	30233N1

EXCEL ELECTRONIC FILE OF THE UB-04 INPATIENT DATA TEMPLATE

COUNTY OF LOS ANGELES●DEPARTMENT OF HEALTH SERVICES

NON-COUNTY HOSPITALS

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 INPATIENT DATA

GENERAL INFORMATION

Hospitals must submit an **Excel Electronic File of the UB-04 data** with the paper copy of the trauma claim packet to the EMS Agency. Data is to be captured from the UB-04 data fields as indicated below:

(Inpatient Template listing order)

Column letter and number	UB Field No.	FIELD NAME	INSTRUCTIONS FOR INPATIENT TEMPLATE
A-C	N/A	Clm#/Hosp Code/FY	•Leave blank-EMS will complete
D	8b	LAST NAME	•Enter patient's last name
E	8b	FIRST NAME	•Enter patient's first name
F	60	Seq#	•Enter the TPS # Insured's unique ID
G	N/A	(LOS) Length of Stay	•Leave blank -EMS will complete
H	4	Type of bill	•Enter IP for 111=Inpatient
I	6	Admission Date	•Enter the from (admit date)
J	6	Discharge Date	•Enter the through (discharge date)
K	47	TOTAL CHARGES	•Enter Total Charges
L-1	N/A	GPP Service Category, Tier, and Type	• Leave Blank
M-2	57	Facility ID number	•Leave blank-EMS will complete
N-3	56	National Provider Identifier	•Leave blank-EMS will complete
O-4	3a Pat Cntl#	Unique patient ID	•Enter patient's unique number assigned by provider
P-5	6	Admission Date	Enter admit date as yyyymmdd
Q-6	6	Discharge Date	Enter discharge date as yyyymmdd
R-7	N/A	# of GPP Days	•Leave blank

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 INPATIENT DATA

Column letter and number	UB Field No	FIELD NAME	INPATIENT TEMPLATE INSTRUCTIONS
S-8	42	REVENUE CODE	•Enter the appropriate numeric code to identify specific accommodations and/or ancillary service in ascending numeric order, by date of service if appropriate. For example: •209 (ICU)
T-9	67	PRINCIPAL DIAGNOSIS	•Enter the complete ICD-10-CM diagnosis code that describes the principal diagnosis or the chief reason for performing a service on an outpatient basis.
U-10 AR-33	67a-67x	OTHER DX CODES	•Enter the complete ICD-10-CM diagnosis codes for up to 17 additional conditions **If applicable**
AS-34	74	Principal Procedure Code	•Enter the ICD code that identifies the principal procedure
AT-35 AX-39	74a-e	Other procedure Code/Date	•Enter other ICD codes identifying all significant procedures performed. •Enter the date of those procedures. **If applicable**
AY-40 BQ-58	74f-x	Other procedure 6-24	•Leave blank
BR-59	10	BIRTHDATE	•Enter patient's date of birth yyyymmdd
BS-60	11	Gender Identity	•Leave blank-EMS will complete
BT-61	9D	ZIP CODE	•Enter patient's Zip Code
BU-62	N/A	Race	•Leave blank-EMS will complete
BV-63	N/A	Race 1	•Leave blank-EMS will complete
BW-64	N/A	Race 2	•Leave blank-EMS will complete
BX-65	N/A	Ethnicity	•Leave blank-EMS will complete
BY-66	N/A	Preferred Language Spoken	•Leave blank
BZ-67	N/A	Sexual Orientation	•Leave blank-
CA-68	N/A	Length of Stay	•Leave blank-EMS will complete
CB-69	N/A	Jimmy's Comments	•Leave blank-EMS will complete

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 INPATIENT DATA

Column A	Column B	Column C	Column D	Column E	Column F	Column G
Clm #	**Hosp Code**	**FY**	**Last Name**	**First Name**	**Seq #**	**LOS**
BOX # ON UB	**1**		**8b**	**8b**	**60**	**45**
EMS will complete	**EMS will complete**	**EMS will complete**	**DOE**	**JOHN**	**C12345678901**	**EMS will complete**

Column H	Column I	Column J	Column K	Column L
IP	**Admission Date**	**Discharge Date**	**Total Charges**	**GPP Service Category, Tier, and Type**
				(1)
				Four-digit code to distinguish each GPP service type. First digit represents service category, second digit represents tier, and last two digits represent service type
4	**6**	**6**	**47**	**N/A**
IP	**07/27/2018**	**08/02/2018**	**$ 157,689.60**	***leave blank***

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 INPATIENT DATA

Column M N

Facility ID number	National Provider Identifier
(2)	(3)
Can be OSHPD's 6-digit ID number (hospital), or other facility ID number (state provider code, tax ID, etc). If no facility ID or using NPI to identify facility, then 000000	NPI Identification Number; 0000000000 if unknown
57	56
EMS will Complete	EMS will Complete

Column O P Q R

Unique patient ID	Admission Date	Discharge Date	# of GPP days
(4)	(5)	(6)	(7)
Unique patient identification number (May not be unique across organization)	Single-digit months and days must include a preceding zero. yyyymmdd.	Single-digit months and days must include a preceding zero. yyyymmdd.	Normally Discharge date - Admission date. However, limited scope will have a lower number of days.
3a	6	6	N/A
123456789	20180727	20180802	*leave blank*

Column S T U V W

Revenue Code	Principal diagnosis	Other diagnosis 1	Other diagnosis 2	Other diagnosis 3
(8)	(9)	(10)	(11)	(12)
Revenue Code used on UB04 (I/P ward)	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file
42	67	67a	67b	67c
0200	S02651B	J9600	R402112	R402222

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 INPATIENT DATA

Column	X	Y	Z	AA	AB
	Other diagnosis 4	**Other diagnosis 5**	**Other diagnosis 6**	**Other diagnosis 7**	**Other diagnosis 8**
	(13)	**(14)**	**(15)**	**(16)**	**(17)**
	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file
	67d	**67e**	**67f**	**67g**	**67h**
	R402342	**S0232XB**	**S022XXA**	**H1132**	**S02652B**

Column	AC	AD	AE	AF	AG
	Other diagnosis 9	**Other diagnosis 10**	**Other diagnosis 11**	**Other diagnosis 12**	**Other diagnosis 13**
	(18)	**(19)**	**(20)**	**(21)**	**(22)**
	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file
	67i	**67j**	**67k**	**67l**	**67m**
	S0240FA	**N200**	**S199XXA**	**R55**	**T401X4A**

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 INPATIENT DATA

Column AH	Column AI	Column AJ	Column AK	Column AL
Other diagnosis 14	**Other diagnosis 15**	**Other diagnosis 16**	**Other diagnosis 17**	**Other diagnosis 18**
(23)	**(24)**	**(25)**	**(26)**	**(27)**
ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file
67n	**67o**	**67p**	**67q**	**67r**
Z23	**T401X4A**	**Z24**	**T401X4A**	**Z25**

Column AM	Column AN	Column AO	Column AP	Column AQ
Other diagnosis 19	**Other diagnosis 20**	**Other diagnosis 21**	**Other diagnosis 22**	**Other diagnosis 23**
(28)	**(29)**	**(30)**	**(31)**	**(32)**
ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file
67s	**67t**	**67u**	**67v**	**67w**
T401X4A	**Z26**	**T401X4A**	**Z27**	**T401X4A**

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 INPATIENT DATA

Column AR	AS	AT	AU	AV
Other diagnosis 24	**Principal procedure**	**Other Procedure 1**	**Other Procedure 2**	**Other Procedure 3**
(33)	**(34)**	**(35)**	**(36)**	**(37)**
ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 PSC; Fill from the left-most position and DO NOT skip fields When there are no Other Procedures, the default value is all spaces	ICD-10 PSC; Fill from the left-most position and DO NOT skip fields When there are no Other Procedures, the default value is all spaces	ICD-10 PSC; Fill from the left-most position and DO NOT skip fields When there are no Other Procedures, the default value is all spaces (max 20)	ICD-10 PSC; Fill from the left-most position and DO NOT skip fields When there are no Other Procedures, the default value is all spaces (max 20)
67x	**74**	**74a**	**74b**	**74c**
Z28	**0NSN04Z**	**0NSTXZZ**	**0NSVXZZ**	**5A1935Z**

Column AW	AX	AY	BQ
Other Procedure 4	**Other Procedure 5**	**Other Procedure 6**	**Other Procedure 24**
(38)	**(39)**	**(40)**	**(58)**
ICD-10 PSC; Fill from the left-most position and DO NOT skip fields When there are no Other Procedures, the default value is all spaces (max 20)	ICD-10 PSC; Fill from the left-most position and DO NOT skip fields When there are no Other Procedures, the default value is all spaces (max 20)	ICD-10 PSC; Fill from the left-most position and DO NOT skip fields When there are no Other Procedures, the default value is all spaces (max 20)	ICD-10 PSC; Fill from the left-most position and DO NOT skip fields When there are no Other Procedures, the default value is all spaces (max 20)
74d	**74e**	**74f**	**74x**
0BH17EZ	**2W31X9Z**	**Leave blank**	**Leave blank**

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 INPATIENT DATA

Column BR	BS	BT
Date of Birth	**Gender Identity**	**Zipcode**
(59)	**(60)**	**(61)**

Single-digit months and days must include a preceding zero. yyyymmdd.	446151000124109 - Male
	446141000124107 - Female
	407377005 - Female-to-Male (FTM)/ Transgender Male/Trans Man
	407376001 - Male-to-Female (MTF)/ Transgender Female/Trans Woman
	446131000124102 - Genderqueer, Non-binary, neither exclusively male nor female
	OTH - Additional gender category or other, please specify
	ASKU - Choose not to disclose
		XXXXX = unknown;
		yyyyy = foreign;
		zzzzz = homeless;

10	**Not on UB**	**9d**
19720821	**EMS will complete**	**Enter Zip Code**

Column BU	BV	BW
Race	**Race 1**	**Race 2**
(62)	**(63)**	**(64)**
Allow for reporting of multiple race fields: 1 – American Indian or Alaska Native 2 – Asian 3 – Black or African American 4 – Native Hawaiian or Other Pacific Islander 5 –White 6 – Other 7 – Unknown 8 - Declined to Answer	**Allow for reporting of multiple race fields:** 1 – American Indian or Alaska Native 2 – Asian 3 – Black or African American 4 – Native Hawaiian or Other Pacific Islander 5 –White 6 – Other 7 – Unknown 8 - Declined to Answer	**Allow for reporting of multiple race fields:** 1 – American Indian or Alaska Native 2 – Asian 3 – Black or African American 4 – Native Hawaiian or Other Pacific Islander 5 –White 6 – Other 7 – Unknown 8 - Declined to Answer
Not on UB	**Not on UB**	**Not on UB**
EMS will complete	**EMS will complete**	**EMS will complete**

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 INPATIENT DATA

Column BX

Column BY

Ethnicity	Preferred Language Spoken
(65)	(66)
1 – Hispanic or Latino 2 – Non-Hispanic or Non-Latino 3 – Unknown 4 – Declined to Answer	In alignment with the Department of Health Care Access and Information (HCAI) reporting, systems must report using one of the following options: • 3-character PLS codes listed in CA Title 22 Regulations (section 97234); OR • 3-character PLS codes from the ISO 639-2 Code List; OR • If the preferred language spoken is not one of the codes listed, enter the full name of the language, up to 24 characters • Report 999 for Unknown
Not on UB	**Not on UB**
EMS will complete	**leave blank**

Column BZ

Column CA

Column CB

Sexual Orientation	LOS	Jimmy's Comments
(67)	(68)	(69)
38628009 - Lesbian, gay or homosexual 20430005 - Straight or hetrosexual 42035005 - Bisexual OTH - Something else UNK - Don't know ASKU - Choose not to disclose		- If column CA is not equal to “0”, please explain below the reason your LOS is different from the formula. - If the patient has a ficticious name such as “Trauma” or “John Doe” or "Jane Doe", please validate and comment below. - If the patient has DOB is unknown, please validate and comment below. - Please explain anything below that you consider is important to be noted.
Not on UB	LOS	**Not on UB**
leave blank	**EMS will complete**	**EMS will complete**

EXCEL ELECTRONIC FILE OF THE UB-04 OUTPATIENT DATA TEMPLATE

COUNTY OF LOS ANGELES●DEPARTMENT OF HEALTH SERVICES

NON-COUNTY HOSPITALS

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 OUTPATIENT DATA

GENERAL INFORMATION

Hospitals must submit an **Excel Electronic File of the UB-04 data** with the paper copy of the trauma claim packet to the EMS Agency. Data is to be captured from the UB-04 data fields as indicated below:

(Outpatient Template listing order)

Column Letter and Number	UB Field No.	FIELD NAME	INSTRUCTIONS FOR OUTPATIENT TEMPLATE
A-C	N/A	Clm #/Hosp Code/FY	•Leave blank-EMS will complete
D	8b	Last Name	•Enter patient's last name
E	8b	First Name	•Enter patient's first name
F	60	Insured's unique ID	•Enter the Sequence (TPS) #
G	4	VISIT	•Enter 1 for Outpatient claims
H	4	ED	•Enter ED for Code 131=Outpatient
I	6	Admission Date	•Enter date Statement Covers Period **From**
J	6	Discharge Date	•Enter date Statement Covers Period **Through**
K	47	TOTAL CHARGES	•Enter Total Charges
L-1	N/A	GPP Service Category, Tier, and Type	•Leave blank
M-2	57	Facility ID number	•Leave blank-EMS will complete
N-3	56	National Provider Identifier	•Leave blank-EMS will complete
O-4	3a Pat Cntl#	Unique patient ID	•Enter patient's unique number assigned by provider
P-5	6	Service Date	•Enter the from (admit date) as yyyymmdd
Q-6	N/A	# of GPP Units	•Leave blank

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 OUTPATIENT DATA

Column Letter and Number	UB Field No.	FIELD NAME	INSTRUCTIONS FOR OUTPATIENT TEMPLATE
R-7	67	PRINCIPAL DIAGNOSIS	•Enter the complete ICD-10-CM diagnosis code that describes the principal diagnosis or the chief reason for performing a service on an outpatient basis.
S-8 - AP-31	67A-67X	OTHER DX CODES	•Enter the complete ICD-10-CM diagnosis codes for up to 17 additional conditions **If applicable**
AQ-32	74 or 44 (CPT code)	Principal procedure	•CPT-4 code set (Current Procedural Terminology, 4th Edition); Fill from the left-most position IE (99291)
AR-33 - CN-81	N/A	Principal Procedure Code modifier	•Leave blank
CO-82	10	Date of Birth	•Enter yyyymmdd
CP-83	11	Gender Identity	•Leave blank-EMS will complete
CQ-84	9D	ZIP CODE	•Enter patient's Zip Code
CR-85	N/A	Race	•Leave blank-EMS will complete
CS-86	N/A	Race 1	•Leave blank
CT-87	N/A	Race 2	•Leave blank
CU-88	N/A	Ethnicity	•Leave blank-EMS will complete
CV-89	N/A	Preferred Language	•Leave blank
CW-90	N/A	Sexual Orientation	•Leave blank-
CX-91	N/A	Length of stay	•Leave blank-EMS will complete
CY-92	N/A	Jimmy's Comments	•Leave blank-EMS will complete

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 OUTPATIENT DATA

Column

A	B	C	D	E	F	G	H
Clm #	**Hosp Code**	**FY**	**Last Name**	**First Name**	**Seq #**	**Visit**	**ED**
BOX # ON UB	**1**		**8b**	**8b**	**60**	**6**	**4**
EMS will complete	***EMS will complete***	***EMS will complete***	***DOE***	***JOHN***	***CI234567890***	***1***	***ED***

Column

I	J	K	L
Admission Date	**Discharge Date**	**Total Charges**	**GPP Service Category, Tier, and Type**
			1
			Four-digit code to distinguish each GPP service type. First digit represents service category, second digit represents tier, and last two digits represent service type (see column A of "service cat_tier_type codes" tab)
6	**6**	**47**	**N/A**
12/31/2018	***12/31/2018***	***$26,209.60***	***leave blank***

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 OUTPATIENT DATA

Column

M	N
Facility ID number	**National Provider Identifier**
2	**3**
OSHPD's 6-digit ID number (hospital), or other facility ID number (state provider code, tax ID, etc). If no facility ID or using NPI to identify facility, then 000000	**NPI** Identification Number; 0000000000 if unknown
57	**56**
EMS will complete	***EMS will complete***

Column

O	P
Unique patient ID	**Service Date**
4	**5**
Unique patient identification number (May not be unique across organization)	Single-digit months and days must include a preceding zero. The transmittal process will populate the database field by moving the first 4 digits to the end of the field. EXAMPLE: Field in File equals 20040301. Database value will contain 03012004. The database value represents the date format mmddccyy.
3a	**6 Admit date only**
1213456789	***20181231***

Column

Q	R	S	T	U	V
# of GPP days	**Principal diagnosis**	**Other diagnosis 1**	**Other diagnosis 2**	**Other diagnosis 3**	**Other diagnosis 4**
6	**7**	**8**	**9**	**10**	**11**
Number of GPP services provided	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file
N/A	**67**	**67A**	**67B**	**67C**	**67D**
leave blank	***S01412A***	***S41012A***	***S41011A***	***S41111A***	***S51821A***

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 OUTPATIENT DATA

Column W X Y Z AA AB

Other diagnosis 5	Other diagnosis 6	Other diagnosis 7	Other diagnosis 8	Other diagnosis 9	Other diagnosis 10
12	13	14	15	16	17
ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file
67E	**67F**	**67G**	**67H**	**67I**	**67J**
S810012A	***S51821A***	***S810012A***	***S51821A***	***S810012A***	***S51821A***

Column AC AD AE AF AG AH

Other diagnosis 11	Other diagnosis 12	Other diagnosis 13	Other diagnosis 14	Other diagnosis 15	Other diagnosis 16
18	19	20	21	22	23
ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file
67K	**67L**	**67M**	**67N**	**67O**	**67P**
S810012A	***S51821A***	***S810012A***	***S51821A***	***S810012A***	***S51821A***

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 OUTPATIENT DATA

Column

AI	AJ	AK	AL	AM	AN
Other diagnosis 17	**Other diagnosis 18**	**Other diagnosis 19**	**Other diagnosis 20**	**Other diagnosis 21**	**Other diagnosis 22**
24	**25**	**26**	**27**	**28**	**29**
ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file
67Q	**67R**	**67S**	**67T**	**67U**	**67V**
S810012A	***leave blank***	***leave blank***	***leave blank***	***leave blank***	***leave blank***

Column

AO	AP	AQ	AR through CN	
Other diagnosis 23	**Other diagnosis 24**	**Principal procedure**	**Principal Procedure Code modifier**	**Other Procedure code 24 modifier**
30	**31**	**32**	**33**	**81**
ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	ICD-10 CM; Code must be left-justified and space-filled; Do not include the decimal point in the data file	CPT-4 code set (Current Procedural Terminology, 4th Edition); Fill from the left-most position and DO NOT skip fields When there are no Other Procedures, the default value is all spaces	CPT and HCPCS Modifiers associated with the specified GPP service codes. (Refer to the specific GPP services description for the allowable codes). If multiple modifiers are reported for the same principal procedure code, use comma delimited	ICD-10 PSC; Fill from the left-most position and DO NOT skip fields When there are no Other Procedures, the default value is all spaces
67W	**67X**	**74 or 44 (CPT code)**	**74A**	**74Y**
leave blank	***leave blank***	***99291***	***leave blank***	***leave blank***

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 OUTPATIENT DATA

Column CO / CP / CQ

Date of Birth	Gender Identity	Zip code
82	83	84

Single-digit months and days must include a preceding zero. yyyymmdd.	446151000124109 - Male
	446141000124107 - Female
	407377005 - Female-to-Male (FTM)/ Transgender Male/Trans Man
	407376001 - Male-to-Female (MTF)/ Transgender Female/Trans Woman
	446131000124102 - Genderqueer, Non-binary, neither exclusively male nor female
	OTH - Additional gender category or other, please specify
	ASKU - Choose not to disclose
		XXXXX = unknown;
		yyyyy = foreign;
		zzzzz = homeless;

10	11	9D
19841001	EMS will complete	Enter Zip Code

Column CR / CS / CT

Race	Race 1	Race 2
85	86	87
Allow for reporting of multiple race fields: 1 – American Indian or Alaska Native 2 – Asian 3 – Black or African American 4 – Native Hawaiian or Other Pacific Islander 5 –White 6 – Other 7 – Unknown 8 - Declined to Answer	**Allow for reporting of multiple race fields:** 1 – American Indian or Alaska Native 2 – Asian 3 – Black or African American 4 – Native Hawaiian or Other Pacific Islander 5 –White 6 – Other 7 – Unknown 8 - Declined to Answer	**Allow for reporting of multiple race fields:** 1 – American Indian or Alaska Native 2 – Asian 3 – Black or African American 4 – Native Hawaiian or Other Pacific Islander 5 –White 6 – Other 7 – Unknown 8 - Declined to Answer
Not on UB	Not on UB	Not on UB
EMS will complete	Leave blank	Leave blank

INSTRUCTIONS FOR COMPLETION OF THE EXCEL ELECTRONIC FILE OF THE UB-04 OUTPATIENT DATA

Column CU

Ethnicity
88
1 – Hispanic or Latino 2 – Non-Hispanic or Non-Latino 3 – Unknown 4 – Declined to Answer
Not on UB
EMS will complete

Column CV

Preferred Language
89
In alignment with the Department of Health Care Access and Information (HCAI) reporting, systems must report using one of the following options: • 3-character PLS codes listed in CA Title 22 Regulations (section 97234); OR • 3-character PLS codes from the ISO 639-2 Code List; OR • If the preferred language spoken is not one of the codes listed, enter the full name of the language, up to 24 characters • Report 999 for Unknown
Not on UB
Leave blank

Column CW

Sexual Orientation
90
38628009 - Lesbian, gay or homosexual 20430005 - Straight or hetrosexual 42035005 - Bisexual OTH - Something else UNK - Don't know ASKU - Choose not to disclose
Not on UB
Leave blank

Column CX

LOS Length of stay
91
Not on UB
EMS will complete

Column CY

Jimmy's Comments
92
- If column CX is not equal to “0”, please explain below the reason your LOS is different from the formula. - If the patient has a fictitious name such as “Trauma” or “John Doe” or "Jane Doe", please validate and comment below. - If the patient has DOB is unknown, please validate and comment below. - Please explain anything below that you consider is important to be noted.
Not on UB
EMS will complete

INSTRUCTIONS FOR COMPLETION OF THE TRAUMA PAYMENT SURRENDER FORM

NON-COUNTY HOSPITALS

INSTRUCTIONS FOR COMPLETION OF THE TRAUMA CENTER PAYMENT SURRENDER FORM

GENERAL INFORMATION

Any and all payments received by Contractor from a Trauma Patient or from third-party payers, including a legal settlement, for a claim previously submitted to and not rejected by the County, must be immediately reported to the County and the payment amount shall be surrendered and remitted to the County since Contractor assigned and subrogated its rights to said claim. Contractor must remit to the County the payment it received within sixty (60) days of receipt of such payment and must complete and submit a TRAUMA CENTER PAYMENT SURRENDER FORM with each surrendered payment.

COMPLETION OF THE TRAUMA CENTER PAYMENT SURRENDER FORM

1. FACILITY
   Enter the Trauma Center refunding the claim

2. PATIENT NAME
   Enter the patient's name of claim being refunded

3. DATE OF SERVICE
   Enter the patient's date of service

4. TPS#
   Enter the Trauma Patient Sequence Number

5. DATE CLAIM SUBMITTED TO EMS AGENCY
   Enter the date that trauma claim was submitted to EMS

6. AMOUNT OF PAYMENT BEING SURRENDERED
   Enter the amount being refunded to EMS:

7. PAYMENT RECEIVED FROM
   Check appropriate box to Indicate whom provided the refund

   ☐INSURANCE (Health Plan/HMO)

   ☐MEDI-CAL

   ☐MEDICARE

   ☐PATIENT

   ☐THIRD PARTY TORTFEASORS

   ☐OTHER _____
   (Specify)

INSTRUCTIONS FOR COMPLETION OF THE TRAUMA CENTER PAYMENT SURRENDER FORM

8. DATE COVERAGE IDENTIFIED
   Enter the date coverage identified

9. SUBMITTED BY
   Enter the name of person submitting the refund

10. DATE
    Enter the date of refund

11 ATTACH COPY OF TRAUMA CENTER SURRENDER FORM
   This form must be attached to each payment surrender check

12. MAIL REFUND TO
    Los Angeles County/Department of Health Services
    Finance – Special Program Funds
    1000 S. Fremont Avenue
    Unit 8, Building A11, 2nd Floor
    Alhambra, CA 91803

COUNTY OF LOS ANGELES•DEPARTMENT OF HEALTH SERVICES
EMERGENCY MEDICAL SERVICES AGENCY

TRAUMA CENTER PAYMENT SURRENDER FORM

FACILITY: _____

PATIENT NAME: _____

DATE OF SERVICE: _____/_____/_____ TPS#: _____

DATE CLAIM SUBMITTED TO EMS AGENCY: _____/_____/_____

AMOUNT OF PAYMENT BEING SURRENDERED: $_____

PAYMENT RECEIVED FROM	**DATE COVERAGE IDENTIFIED**
☐INSURANCE (Health Plan/HMO)	_____/_____/_____
☐MEDI-CAL	_____/_____/_____
☐MEDICARE	_____/_____/_____
☐PATIENT	_____/_____/_____
☐THIRD PARTY TORTFEASORS	_____/_____/_____
☐OTHER _____ (Specify)	_____/_____/_____

_____ _____/____/_____
SUBMITTED BY DATE:

(THIS FORM MUST BE ATTACHED TO EACH PAYMENT SURRENDER CHECK)

Mail to: Los Angeles County/Department of Health Services
Finance – Special Program Funds
1000 S. Fremont Avenue
Unit 8, Building A11, 2nd Floor
Alhambra, CA 91803

TRAUMA CENTER PAYMENT SURRENDER FORM

FACILITY: _____

PATIENT NAME: _____

DATE OF SERVICE: _____/_____/_____ TPS#: _____

DATE CLAIM SUBMITTED TO EMS AGENCY: _____/_____/_____

AMOUNT OF PAYMENT BEING SURRENDERED: $_____

PAYMENT RECEIVED FROM	**DATE COVERAGE IDENTIFIED**
☐INSURANCE (Health Plan/HMO)	_____/_____/_____
☐MEDI-CAL	_____/_____/_____
☐MEDICARE	_____/_____/_____
☐PATIENT	_____/_____/_____
☐THIRD PARTY TORTFEASORS	_____/_____/_____
☐OTHER _____ (Specify)	_____/_____/_____

_____ SUBMITTED BY:

_____/_____/_____ DATE:

(THIS FORM MUST BE ATTACHED TO EACH PAYMENT SURRENDER CHECK)

Mail to Los Angeles County/Department of Health Services
Finance – Special Program Funds
1000 S. Fremont Avenue
Unit 8, Building A11, 2nd Floor
Alhambra, CA 91803