Policy:	FF.1007
Title:	**Health Network Reinsurance Coverage**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 05/09/2024*
Effective Date:	01/01/2007
Revised Date:	05/01/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy sets forth CalOptima Health's reinsurance coverage for Health Networks, excluding any Health Maintenance Organizations (HMOs) that are financially at-risk for catastrophic claims.

II. POLICY

A. CalOptima Health shall provide reinsurance coverage to its eligible Health Networks, in accordance with this Policy.

B. Effective July 1, 2023, claims for services to Members eligible for California Children's Services (CCS) Program shall be included in this Policy.

C. The coverage period for this policy is each CalOptima Health fiscal year beginning 12:01 a.m. Pacific Time (PT) July 1, through 12:00 a.m. PT June 30.

D. Reinsurance coverage applies to claims incurred within the coverage period and paid by the eligible Health Network no later than six (6) months after the end of the coverage period.

E. An eligible Health Network shall submit reinsurance claims to CalOptima Health no later than December 31, following the end of the previous fiscal year to be eligible for reimbursement:

1. An eligible HMO may submit reinsurance claims for covered hospital and covered physician expenses;

2. A Primary Physician Group may submit reinsurance claims for covered physician expenses;

3. A Primary Hospital may submit reinsurance claims for covered hospital expenses; and

4. A Shared Risk Group (SRG) may submit reinsurance claims for covered physician expenses.

F. CalOptima Health shall identify reinsurance claims and payment of benefits for hospital expenses for Members assigned to an SRG, in accordance with CalOptima Health Policy FF.1010: Shared Risk Pool.

G. Covered expenses include those Covered Services that are delegated to an eligible Health Network, and Shared Risk services, as defined in the Division of Financial Responsibility (DOFR) between CalOptima Health and the eligible Health Network, except those services listed in Section II.H of this Policy.

1. Covered hospital expenses are either:

a. Those Covered Services listed in the DOFR between CalOptima Health and a Primary Hospital in the Contract for Health Care Services – Hospital; or

b. Those Covered Services listed in the DOFR between CalOptima Health and an eligible HMO in the Contract for Health Care Services; or

c. Shared Risk services listed in the DOFR between CalOptima Health and a Shared Risk Group in the Contract for Health Care Services – Physician (Shared Risk).

2. Covered physician expenses are either:

a. Those Covered Services listed in the DOFR between CalOptima Health and a Primary Physician Group in the Contract for Health Care Services – Physician; or

b. Those Covered Services listed in the DOFR between CalOptima Health and an eligible HMO in the Contract for Health Care Services; or

c. Shared Risk services listed in the DOFR between CalOptima Health and a Shared Risk Group in the Contract for Health Care Services – Physician (Shared Risk).

H. Covered expenses exclude Capitation Payments, and any other non-Covered Service, exclusion, or Covered Service that is not a Shared Risk service that is the financial responsibility of CalOptima Health. This includes covered Transplant services, and Health Network Transplant claims denied for payment due to administrative reasons (e.g., timeliness).

I. Covered expenses are subject to the following limitations:

1. Hospital services:

a. For contracted hospital inpatient services, the lesser of the amount paid for covered hospital expenses, the negotiated rate, billed charges, or the Contracted CalOptima Health Direct (COHD) Hospital Rate, averaged over the entire length of stay or stays.

b. For non-contracted hospital inpatient services, the lesser of the amount paid for covered hospital expenses, the negotiated rate, billed charges, or the non-contracted COHD hospital rate, averaged over the entire length of stay or stays.

i. For non-contracted emergency hospital inpatient services, the lesser of the amount paid for covered hospital expenses, the negotiated rate, or billed charges, averaged over the entire length of stay or stays, up to the amount specified for non-contracted emergency hospital inpatient services in CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group.

ii. For non-contracted post-stabilization inpatient services, up to the amount specified for non-contracted post-stabilization inpatient services, in accordance with CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Health Direct, or a Member Enrolled in a Shared Risk Group, and Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Health Direct-Administrative Members, CalOptima Health Community Network Members, or Members Enrolled in a Shared Risk Group.

iii. For non-contracted out-of-state emergency hospital inpatient services, the lesser of the amount paid for covered hospital expenses, the negotiated rate, or billed charges, averaged over the entire length of stay or stays, up to the All Patient Refined Diagnosis-Related Groups (APR-DRG) paid by Medi-Cal Fee-For-Service for out-of-State hospital inpatient services.

c. All calculations shall be made prior to the application of Deductible or coinsurance. CalOptima Health shall accept a completed UB-04 form as proof of payment for capitated hospital services. A hospital shall not include any loss for home health services or outpatient services, or for days of confinement in an extended care facility or rehabilitation facility.

2. Physician services:

a. The lesser of the amount paid for covered physician expenses or:

i. One hundred twenty-nine percent (129%) of the current CalOptima Health Medi-Cal Fee Schedule in effect on the date of service; or

ii. Fifty percent (50%) of the amount paid if Medi-Cal has no value for the five-digit numerical Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, or other code as assigned by the Department of Health Care Services (DHCS).

b. The above calculation shall be made prior to the application of Deductible or coinsurance. CalOptima Health shall accept a completed CMS-1500 form as proof of payment for capitated physician services.

3. Hemodialysis services: Limited to one thousand dollars ($1,000) per calendar day.

4. Chemotherapy drugs and related services: Limited to one thousand dollars ($1,000) per calendar day, for services billed as a medical claim.

5. In the absence of other limitations, CalOptima Health shall calculate covered expenses by summing all hospital or physician covered expenses per Member per coverage period, as applicable by Section II.E of this Policy, subject to the annual Deductible.

J. Annual Deductibles are as follows:

1. Hospital Deductible:

a. One hundred fifty thousand dollars ($150,000) of covered hospital expenses per Member during the coverage period.

b. Subject to the terms of this policy, CalOptima Health shall reimburse eighty percent (80%) of the expenses after a Deductible of one hundred fifty thousand dollars ($150,000) is applied.

2. Physician Deductible:

a. Seventeen thousand dollars ($17,000) of covered physician expenses per Member during the coverage period.

b. Subject to the terms of this policy, CalOptima Health shall reimburse eighty percent (80%) of the expenses after a Deductible of seventeen thousand dollars ($17,000) is applied.

K. The maximum reinsurance amount payable under this policy for covered expenses for a Member is calculated on the basis of one million dollars ($1,000,000) of coverage per Member per coverage period, minus the applicable annual Deductible and coinsurance, and subject to any limitations noted in this Policy.

III. PROCEDURE

A. Process to submit reinsurance claims for covered expenses, except hospital expenses for a Member assigned to a Shared Risk Group:

1. An eligible Health Network shall submit reinsurance claims on a quarterly basis, no later than the twentieth (20th) calendar day of the month following the end of a quarter.

2. An eligible Health Network shall submit reinsurance claims using CalOptima Health's proprietary format and file naming convention, as described in the Reinsurance Field Names and Values for Electronic File Transmission. An eligible Health Network may submit the reinsurance claims file by transmitting an encrypted electronic mail to reinsurance@caloptimahealth.org, submitting electronically to CalOptima Health's secure FTP site, or by mailing an encrypted Universal Serial Bus (USB) flash drive, compact disk (CD) or Digital Versatile Disc (DVD) to:

Attn: Coding Initiatives Department—Reinsurance Claims
CalOptima Health
505 City Parkway West
Orange CA 92868

3. Reinsurance claims shall include:

a. Claims paid by an eligible Health Network during that quarter only; or

b. Claims detail for qualified Members who reached the annual Deductible.

4. Upon request, an eligible Health Network shall provide detailed support, within ten (10) business days, for any individual claim for which billed charges are greater than, or equal to, ten thousand dollars ($10,000), including copies of the claim form, cancelled check, explanation of benefits (EOB), Remittance Advice Detail (RAD), and other information, as requested by CalOptima Health. All non-contracted emergency hospital inpatient claims require submission of the authorization distinguishing days considered emergency and post-stabilization.

5. CalOptima Health shall notify an eligible Health Network of file acceptance or rejection within ten (10) business days after receipt.

    a. CalOptima Health may reject a file for any missing information or incorrect data.

    b. If CalOptima Health rejects a file, the eligible Health Network shall resubmit a corrected file within five (5) business days from receipt of notification from CalOptima Health.

6. CalOptima Health shall provide an eligible Health Network with detailed reports of claims processed within forty-five (45) business days after the quarter end submission date.

7. An eligible Health Network may appeal claim denials and underpayments within sixty (60) business days after the date of CalOptima Health's RAD.

    a. The eligible Health Network shall submit a request for appeal, in writing, to CalOptima Health at reinsurance@caloptimahealth.org or by U.S. mail to:

        Attn: Coding Initiatives Department—Reinsurance Claims
        CalOptima Health
        505 City Parkway West
        Orange CA 92868

    b. The eligible Health Network shall submit the appeals claims submission file in the same format as the initial claims submission, in accordance with the Reinsurance Field Names and Values for Electronic File Transmission.

    c. An appeals claims submission file shall only include specific claims to be reconsidered.

    d. The eligible Health Network shall provide detailed claims support for each claim, including copies of the claim form, cancelled check, EOB, RAD, or any other information, as requested by CalOptima Health.

    e. CalOptima Health shall notify the eligible Health Network of file acceptance or rejection within ten (10) business days after receipt of the appeal file.

        i. CalOptima Health may reject a file for any missing information or incorrect data.

        ii. If CalOptima Health rejects a file, the eligible Health Network shall resubmit a corrected file within five (5) business days after receipt of notification from CalOptima Health.

    f. CalOptima Health shall process an appeal and provide an eligible Health Network with detailed reports within forty-five (45) business days after receipt of the appeal.

B. If a loss exceeds, or is expected to exceed, the annual Deductible by ten thousand dollars ($10,000), CalOptima Health may appoint CalOptima Health staff to represent CalOptima Health's interest in the ongoing administration of the loss. An eligible Health Network shall cooperate with CalOptima Health staff in the ongoing administration of the loss.

C. In the event of termination of the Contract for Health Care Services between an eligible Health Network and CalOptima Health, the coverage period shall end three (3) months after the termination date. A terminated eligible Health Network shall submit reinsurance claims no later than six (6) months after the termination date in order to receive reimbursement.

D. An eligible Health Network shall make books and records available to CalOptima Health for inspection and audit at any time during normal business hours in accordance with the Contract for Health Care Services.

IV. ATTACHMENT(S)

A. Reinsurance Field Names and Values for Electronic File Transmission

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Health Direct or a Member Enrolled in a Shared Risk Group
C. CalOptima Health Policy FF.1010: Shared Risk Pool
D. CalOptima Health Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Health Direct-Administrative Members, CalOptima Health Community Network Members or Members Enrolled in a Shared Risk Group
E. CalOptima Health Policy FF.3001: Financial Reporting
F. Contract for Health Care Services
G. Title 42, United States Code, Section 1396u-2(b)(2)(D)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/10/2010	Department of Health Care Services (DHCS)	Approved as Submitted
08/06/2015	Department of Health Care Services (DHCS)	Approved as Submitted
04/04/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
09/11/2007	Regular Meeting of the CalOptima Board of Directors
09/04/2008	Regular Meeting of the CalOptima Board of Directors
10/01/2009	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	FF.1007 CY2007	Health Network Reinsurance Coverage	Medi-Cal
Revised	09/11/2007	FF.1007 CY2008	Health Network Reinsurance Coverage	Medi-Cal
Revised	09/04/2008	FF.1007 CY2008	Health Network Reinsurance Coverage	Medi-Cal
Revised	01/01/2009	FF.1007 1/09-6/10	Health Network Reinsurance Coverage	Medi-Cal
Revised	07/01/2010	FF.1007_2010-2011	Health Network Reinsurance Coverage	Medi-Cal
Revised	03/01/2012	FF.1007_2011-2012	Health Network Reinsurance Coverage	Medi-Cal
Revised	10/01/2012	FF.1007_2012-2013	Health Network Reinsurance Coverage	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	12/01/2013	FF.1007_2013-2014	Health Network Reinsurance Coverage	Medi-Cal
Revised	04/01/2015	FF.1007_2014-2015	Health Network Reinsurance Coverage	Medi-Cal
Revised	02/01/2016	FF.1007_2015-2016	Health Network Reinsurance Coverage	Medi-Cal
Revised	07/01/2016	FF.1007_2016-2017	Health Network Reinsurance Coverage	Medi-Cal
Revised	07/01/2017	FF.1007_2017-2018	Health Network Reinsurance Coverage	Medi-Cal
Revised	10/04/2018	FF.1007	Health Network Reinsurance Coverage	Medi-Cal
Revised	10/01/2019	FF.1007	Health Network Reinsurance Coverage	Medi-Cal
Revised	12/03/2020	FF.1007	Health Network Reinsurance Coverage	Medi-Cal
Revised	08/01/2021	FF.1007	Health Network Reinsurance Coverage	Medi-Cal
Revised	09/01/2022	FF.1007	Health Network Reinsurance Coverage	Medi-Cal
Revised	07/01/2023	FF.1007	Health Network Reinsurance Coverage	Medi-Cal
Revised	05/01/2024	FF.1007	Health Network Reinsurance Coverage	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
CalOptima Health Direct (COHD)	A direct health care program operated by CalOptima Health that includes both COHD-Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.
Capitation Payment	The monthly amount paid to a Health Network by CalOptima Health for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
Contract for Health Care Services	The written instrument between CalOptima Health and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima Health that is binding on a Physician Hospital Consortium (PHC) or HMO, DHCS Medi-Cal Managed Care Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract.
Covered Services	Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services);

Term	Definition
	4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012.

Term	Definition
Deductible	For purposes of this policy, the amount set forth in Section III.I of this policy, which the eligible Health Network must pay in eligible expenses on behalf of a Member during the coverage period, before CalOptima Health is responsible for reimbursing the eligible Health Network eighty percent (80%) of eligible expenses for that Member.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima Health identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima Health and the County of Orange.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Primary Hospital	A hospital contracted with CalOptima Health on a capitated and delegated basis as the hospital partner of a Physician Hospital Consortium (PHC).
Primary Physician Group	A physician group contracted with CalOptima Health on a capitated and delegated basis as the physician partner of a Physician Hospital Consortium (PHC).
Remittance Advice Detail (RAD)	A summary report, by claim, that supports the detail payment, denial, or adjustment made by check.
Shared Risk Group	A Health Network that accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima Health as the responsible partner for facility services.
Transplant	A Non-Experimental Procedure for human tissue, blood, or organ Transplant.