Policy:	CMC.3001
Title:	**Payment Arrangements to Health Networks – Capitation Payments**
Department:	Finance
Section:	Accounting
CEO Approval:	*/s/ Michael Hunn 05/23/2024*
Effective Date:	07/01/2015
Revised Date:	05/01/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the process for timely and accurate Capitation Payments to a Health Network as set forth in the Cal MediConnect Health Network Contract.

II. POLICY

A. CalOptima Health shall make Capitation Payments to a Health Network in accordance with the Cal MediConnect Health Network Contract and the provisions set forth in this Policy.

B. Capitation Payments shall be a combination of a Medicare component and a Medi-Cal component. For the Medicare component of the Capitation Payment, CalOptima Health shall base a capitation payment on the number of Members enrolled reported by the Centers for Medicare & Medicaid Services (CMS). For the Medi-Cal component, CalOptima Health shall base a Capitation Payment on the number of Members enrolled with CalOptima Health by the California Department of Health Care Services (DHCS).

C. CalOptima Health shall adjust Capitation Payments made to a Health Network for retroactive additions and deletions of Members by CMS and DHCS, in accordance with CMS and DHCS regulations.

D. If CalOptima Health contracts directly with Providers or vendors for services that are partially, or fully, the financial responsibility of a Health Network, CalOptima Health shall deduct the appropriate cost or percentage of cost from the Health Network's Capitation Payment on a quarterly basis.

E. Notwithstanding anything to the contrary contained in the Cal MediConnect Health Network Contract or this Policy, CalOptima Health's obligation to render payments shall be subject to CalOptima Health's receipt of funding from DHCS and CMS.

F. CalOptima Health may recoup any amounts improperly paid to a Health Network by an offset to the following month's Capitation Payment.

G. If a Health Network identifies an overpayment of a Capitation Payment, the Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Health's Accounting Department, in writing, of the reason for

the overpayment. CalOptima Health shall coordinate with the Health Network on the process to return the overpayment.

H. CalOptima Health may adjust a Health Network's capitation rates during the contract period due to changes in CalOptima Health revenue received from CMS and/or DHCS, or changes in CalOptima Health methodologies used to pay capitation to Health Networks. CalOptima Health shall notify Health Networks of adjustments in capitation rates when given advance notice of such adjustments by CMS and/or DHCS.

I. A Health Network shall report a dispute related to payments or enrollments in writing to the CalOptima Health Accounting Department within ninety (90) calendar days after the Health Network's receipt of payment. Failure to dispute within the established time frame indicates acceptance by the Health Network.

III. PROCEDURE

A. Capitation Payment

1. CalOptima Health shall make the Capitation Payments, minus Sanctions or other adjustments, by the twentieth (20^{th}) calendar day of a month for all Members eligible from the first (1st) of that month.

   a. CalOptima Health shall generate the Medicare component of the Capitation Payment in accordance with the Health Network's Contract for Health Care Services, utilizing eligibility information included in the Monthly Membership Report (MMR) from CMS and FACETS™:

      i. MMR includes the current month and adjustments for any prior month, including both Retroactive Terminations of Eligibility with no limit on the look back.

      ii. The Medicare check will be issued for the current and any prior month.

      iii. Within three (3) business days of the check issuance, the CalOptima Health Information Technology Services (ITS) Department shall post a Member-level detail report to CalOptima Health's Secure File Transfer Protocol (SFTP) site, which the Health Network may use to reconcile the Capitation Payment.

   b. CalOptima Health shall generate the Medi-Cal component of the Capitation Payment based on eligibility information loaded in FACETS™:

      i. CalOptima Health shall pay the Capitation Rate for Members on a daily prorated basis with routine adjustments for Retroactive Terminations of Eligibility up to twelve (12) months. The Capitation Payment shall be for the current month and adjustments for the prior twelve (12) months (thirteen (13) total months). In the event Retroactive Terminations of Eligibility implicate potential refunds or recoupments in excess of this timeframe, such actions will be evaluated on a case-by-case basis.

      ii. Within three (3) business days of check issuance, CalOptima Health IS Department shall post a Member-level detail report to CalOptima Health's SFTP site, which the Health Network may use to reconcile the Capitation Payment.

iii. CalOptima Health shall pay the Medi-Cal component of the Capitation Payment based on the Community Well Rate Cohort, unless CalOptima Health's OneCare Connect eligibility records reflect a different MLTSS Rate Cohort.

iv. If CMS eligibility records indicate a Member is eligible and DHCS eligibility records do not, CalOptima Health shall consider the Member eligible and shall pay the Medi-Cal component of the Capitation Payment based on the Community Well Rate Cohort, unless otherwise indicated in CalOptima Health's OneCare Connect eligibility records.

2. Any sub-capitation or other subcontracting arrangements shall be the sole responsibility of the Health Network.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Cal MediConnect Physician Group Services Contract
B. CalOptima Health Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/04/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Reviewed	06/01/2015	CMC.3001	Payment Arrangements to Health Networks– Capitation Payments	OneCare Connect
Effective	07/01/2015	CMC.3001	Payment Arrangements to Health Networks– Capitation Payments	OneCare Connect
Revised	08/01/2016	CMC.3001	Payment Arrangements to Health Networks-Capitation Payments	OneCare Connect
Revised	05/01/2017	CMC.3001	Payment Arrangements to Health Networks-Capitation Payments	OneCare Connect
Revised	7/01/2018	CMC.3001	Payment Arrangements to Health Networks-Capitation Payments	OneCare Connect
Revised	09/01/2019	CMC.3001	Payment Arrangements to Health Networks-Capitation Payments	OneCare Connect
Revised	06/04/2020	CMC.3001	Payment Arrangements to Health Networks-Capitation Payments	OneCare Connect
Revised	07/01/2021	CMC.3001	Payment Arrangements to Health Networks-Capitation Payments	OneCare Connect
Revised	05/01/2022	CMC.3001	Payment Arrangements to Health Networks-Capitation Payments	OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	12/01/2023	CMC.3001	Payment Arrangements to Health Networks-Capitation Payments	OneCare Connect
Revised	05/01/2024	CMC.3001	Payment Arrangements to Health Networks-Capitation Payments	OneCare Connect

IX. GLOSSARY

Term	Definition
Cal MediConnect Health Network Contract	A "Cal MediConnect Physician Group Services Contract," "Cal MediConnect PHC-Physician Group Services Contract," Cal MediConnect PHC-Hospital Services Contract," or "Cal MediConnect HMO Services Contract."
Capitation Payment	The monthly amount paid to a Health Network by CalOptima Health for delivery of Covered Services to Members.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Centers for Medicare & Medicaid Services (CMS) Contract	CalOptima Health's written agreement with the Centers for Medicare & Medicaid Services (CMS) to provide Covered Services under OneCare Connect.
Covered Service	Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California). DHCS is generally referred to as the state in this document.
FACETS™	Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.
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 beneficiary enrolled in the CalOptima Health OneCare Connect program.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes Covered Services.
Rate Cohorts	Department of Health Care Services determined rate categories as follows: 1. Institutional. Individuals in long-term care aid codes and/or residing in a long term care facility for 90 days or more. 2. HCBS High. Individuals identified as high utilizers of HCBS services and who meet one of the following criteria: a. Receiving In-Home Supportive Services (IHSS) and classified as "Severely Impaired" (SI). SI means a person receives at least 20 hours of personal care services per week under the IHSS program; b. Client of a Multipurpose Senior Services Program (MSSP) site, under the associated 1915(c) waiver; or c. Receiving Community-Based Adult Services (CBAS). 3. HCBS Low. Individuals identified as low utilizers of HCBS, receiving IHSS (less than 20 hours of personal care services per week) and classified as "Not Severely Impaired" (NSI) under the IHSS program. 4. Community Well. All other beneficiaries who do not meet criteria for Institutionalized, HCBS High and HCBS Low risk categories.

Term	Definition
Retroactive Terminations of Eligibility	A determination by the Department of Health Care Services (DHCS) or the Centers for Medicare & Medicaid Services (CMS) that a Member who once was eligible is, as of a specified date in the past, no longer eligible for benefits under the specified CalOptima Health program.
Sanction	Action taken by CalOptima Health including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs.