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| Policy: | FF.1009 |
| Title: | **Health-based Risk Adjusted Capitation Payment System** |
| Department: | Finance |
| Section: | Not Applicable |
| *CEO Approval:* | */s/ Michael Hunn 08/08/2024* |
| Effective Date: | 07/01/2008 |
| Revised Date: | 08/01/2024 |
| Applicable to: | ☒ Medi-Cal<br>☐ OneCare<br>☐ PACE<br>☐ Administrative |

## I. PURPOSE

This Policy outlines the process for CalOptima Health's, Health-based Risk Adjusted (HRA) Health Network Capitation Payment system.

## II. POLICY

A. CalOptima Health shall adjust a Health Network's Capitation Payment to a Health-based Risk Adjusted (HRA) Capitation Payment based on the health status of the Health Network's Member population, in accordance with the terms and conditions of this Policy.

B. CalOptima Health shall utilize the Chronic Illness and Disability Payment System (CDPS) to adjust a Health Network's Capitation Payment to an HRA Capitation Payment.

C. Members who are eligible for services under the California Children's Services (CCS) Program shall qualify for risk adjustment under this Policy effective with the July 2023 HRA Capitation Payment in accordance with Section III.D.2.a. of this Policy.

D. CalOptima Health shall risk-adjust a payment for a Member who:

1. Has an Aged, Blind, Disabled, Affordable Care Act (ACA) Expansion, or Temporary Assistance for Needy Families (TANF) Aid Code, or is eligible for services under CCS (effective July 1, 2023);

2. Is enrolled in CalOptima Health for at least six (6) months during a twelve (12) month risk adjustment period as described in Section III.B. of this Policy; and

3. Is enrolled in a Health Network during the periods described in Section III.C. of this Policy.

E. CalOptima Health shall group Members identified in Section II.D.1 into five (5) categories of aid group:

1. Aged, Blind, Disabled members are classified as Seniors or Persons with Disability (SPD);

2. ACA Expansion members are classified as Expansion;

3. TANF members less than nineteen (19) years of age are classified as Child;

4. TANF members more than eighteen (18) years of age are classified as Adult; and

5. CCS members are classified as Whole Child Model (WCM).

F. CalOptima Health shall develop a Risk Assignment Database to contain medical and diagnostic data for Members eligible for risk-adjustment pursuant to Section II.C. of this Policy. CalOptima Health shall utilize the data in the Risk Assignment Database to determine a Member's Risk Score in accordance with Section III.B. of this Policy.

G. CalOptima Health shall calculate a Health Network's risk factor for each category of aid group every six (6) months.

H. CalOptima Health shall apply a Health Network's risk factor for each category of aid group in determining the Health Network's Capitation Payment for the following six (6) month Payment Period.

## III. PROCEDURE

A. Risk Assignment Database

1. The Risk Assignment Database shall contain information including, but not limited to:

   a. Member identification number;

   b. Aid Code;

   c. Diagnosis codes;

   d. Procedure codes; and

   e. National Drug Classification codes.

2. CalOptima Health shall extract information for the Risk Assignment Database from the following service categories:

   a. Inpatient services;

   b. Outpatient services;

   c. Physician services; and

   d. Pharmacy services.

B. Calculation of Member's Risk Score

1. CalOptima Health or its contracted vendor shall utilize the Risk Assignment Database to assign Members a Risk Score using CDPS; each Member's Risk Score is then normalized using the Member's Health Network's capitation age and gender factors. A Health Network's capitation age and gender factors are adjustments that take into account a Health Network's membership's age and gender mix.

2. CalOptima Health or its contracted vendor shall calculate a Member's Risk Score every six (6) months, in April and October.

3. CalOptima Health or its contracted vendor shall calculate a Member's Risk Score based on Encounter and claims data submitted for dates of service over a twelve (12) month risk adjustment period.

    a. For the Risk Score calculated in April ("year 3"), CalOptima Health shall use Encounter data submitted from a Health Network by March 31 ("year 3") for dates of service October ("year 1") through September ("year 2").

    b. For the Risk Score calculated in October ("year 3"), CalOptima Health shall use Encounter data submitted from a Health Network by September 30 ("year 3") for dates of service April ("year 2") through March ("year 3").

4. If a Member is eligible with CalOptima Health for less than six (6) months during a risk adjustment period, CalOptima Health or its contracted vendor shall not calculate a Risk Score for that Member.

C. Calculation of Health Network Risk Factor

1. A Health Network's raw risk factor is the weighted average of all Risk Scores for Members assigned to that Health Network and category of aid group at a defined time, as identified in Section III.C.4. of this policy.

2. CalOptima Health or its contracted vendor shall apply actuarial methodologies to derive statistically significant risk factors for each Health Network.

3. CalOptima Health or its contracted vendor shall calculate a Health Network's risk factor for each category of aid group every six (6) months, in April and October.

4. CalOptima Health or its contracted vendor shall calculate the average Risk Score for Members assigned to that Health Network.

    a. For the risk factor calculated in April, CalOptima Health or its contracted vendor shall use a Health Network's assigned membership as of April.

    b. For the risk factor calculated in October, CalOptima Health or its contracted vendor shall use a Health Network's assigned membership as of October.

    c. CalOptima Health or its contracted vendor shall only use Risk Scores for Members who are eligible as of the months described in Sections III.C.4.a, and III.C.4.b, to calculate a Health Networks' risk factor.

5. CalOptima Health or its contracted vendor shall normalize the average risk factor for each Health Network based on eligible Members in accordance with Section III.C.4 of this Policy, to ensure that the aggregate total Capitation Payments to all Health Networks remains budget neutral to CalOptima Health.

6. CalOptima Health shall notify a Health Network of its risk factor by June 15th and December 15th of each year.

D. Calculation of HRA Capitation Payment

1. CalOptima Health shall multiply a Health Network's monthly base Capitation Payment by the Health Network's risk factor, calculated using the methodology described in Section III.C. of this policy, to determine the Health Network's HRA Capitation Payment.

2. CalOptima Health shall apply a Health Network's risk factor(s) in determining the Health Network's HRA Capitation Payment for the following six (6) month Payment Period as follows:

   a. The risk factor(s) calculated in April shall apply to Capitation Payments for July through December of the same year; and

   b. The risk factor(s) calculated in October shall apply to Capitation Payments for January through June of the following year.

## IV. ATTACHMENT(S)

Not Applicable

## V. REFERENCE(S)

A. CalOptima Health Contract with the California Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health, Health Network Service Agreement
C. CalOptima Health Policy EE.1111: Health Network Encounter Reporting Requirements
D. CalOptima Health Policy FF.1001: Capitation Payments

## VI. REGULATORY AGENCY APPROVAL(S)

| Date | Regulatory Agency | Response |
|---|---|---|
| 09/30/2009 | 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 | Meetings |
|---|---|
| 06/03/2008 | Regular Meeting of the CalOptima Board of Directors |
| 05/05/2009 | Regular Meeting of the CalOptima Board of Directors |
| 06/04/2009 | Regular Meeting of the CalOptima Board of Directors |
| 10/04/2018 | Regular Meeting of the CalOptima Board of Directors |
| 06/04/2020 | Regular Meeting of the CalOptima Board of Directors |

## VIII. REVISION HISTORY

| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Effective | 07/01/2008 | FF.1009 | Health Based Risk Adjusted Capitation Payment System | Medi-Cal |
| Revised | 07/01/2009 | FF.1009 | Health Based Risk Adjusted Capitation Payment System | Medi-Cal |
| Revised | 09/01/2014 | FF.1009 | Health Based Risk Adjusted Capitation Payment System | Medi-Cal |

| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Revised | 06/01/2016 | FF.1009 | Health Based Risk Adjusted Capitation Payment System | Medi-Cal |
| Revised | 05/01/2017 | FF.1009 | Health Based Risk Adjusted Capitation Payment System | Medi-Cal |
| Revised | 10/04/2018 | FF.1009 | Health-based Risk Adjusted Capitation Payment System | Medi-Cal |
| Revised | 12/01/2018 | FF.1009 | Health-based Risk Adjusted Capitation Payment System | Medi-Cal |
| Revised | 10/01/2019 | FF.1009 | Health-based Risk Adjusted Capitation Payment System | Medi-Cal |
| Revised | 07/01/2020 | FF.1009 | Health-based Risk Adjusted Capitation Payment System | Medi-Cal |
| Revised | 08/01/2021 | FF.1009 | Health-based Risk Adjusted Capitation Payment System | Medi-Cal |
| Revised | 09/01/2022 | FF.1009 | Health-based Risk Adjusted Capitation Payment System | Medi-Cal |
| Revised | 07/01/2023 | FF.1009 | Health-based Risk Adjusted Capitation Payment System | Medi-Cal |
| Revised | 08/01/2024 | FF.1009 | Health-based Risk Adjusted Capitation Payment System | Medi-Cal |

## IX. GLOSSARY

| Term | Definition |
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| Aid Code | The two (2) character code, defined by the State of California, which identifies the aid category under which a member is eligible to receive Medi-Cal Covered Services. |
| California Children's Services (CCS) Program | The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9. |
| 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 CalOptima Health Policy DD.2006. |
| 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. |
| Chronic Illness and Disability Payment System (CDPS) | A diagnostic classification system that Medicaid programs utilize to make health-based capitated payments for Temporary Assistance to Needy Families (TANF) and disabled Medicaid beneficiaries. |
| Department of Health Care Services (DHCS) | The single State Department responsible for administration of the Medi-Cal program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs as provided by statute and/or regulation. |
| Encounter | Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services. |
| 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. |
| Health Network Risk Factor | The weighted average of all Member Risk Scores for Members assigned to that Health Network at a defined time, normalized across all Health Networks to ensure that the aggregate total Capitation Payments to all Health Networks is budget neutral to CalOptima Health. |
| 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. |
| Member Risk Score | A measurement of a Member's health status according to a minimum of one (1) diagnostic code. |
| Payment Period | For the purpose of this policy, payment period refers to a set interval of time in which CalOptima Health provides payment to Health Networks for Covered Services furnished to Members. |

| Term | Definition |
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| Risk Assignment Database | A database that contains Members' diagnostic and medical information as reported on the facility and professional Encounter data submitted by a Health Network in accordance with CalOptima Health Policy EE.1111: Health Network Encounter Reporting Requirements, and claims data collected by CalOptima Health for CalOptima Health Direct and Shared Risk Groups. |
| Shared Risk Group | A Health Network who 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. |
| Whole-Child Model (WCM) | An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions. |