Policy:	FF.3002
Title:	**Financial Oversight**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 08/08/2024*
Effective Date:	01/01/2007
Revised Date:	08/01/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the process by which CalOptima monitors a Health Network's financial position and financial security reserves to ensure contract compliance and financial integrity.

II. POLICY

A. CalOptima Health shall conduct Health Network financial reviews and periodic Focused Reviews as it deems necessary. CalOptima Health shall monitor a Health Network's financial position to promote:

1. Access to quality care for Members enrolled in the Health Network;

2. Appropriate and timely payment to Providers that render Covered Services to Members enrolled in the Health Network;

3. Financial integrity of CalOptima Health and its contractors; and

4. Financially prudent utilization of Capitation revenues received from the State of California.

B. Pursuant to the Contract for Health Care Services, CalOptima Health shall ensure that a Health Network complies with Financial Solvency Reserve requirements.

1. Financial Security Reserves - Each entity contracted as a Primary Physician Group, Primary Hospital, or Shared Risk Group (SRG) shall establish and maintain financial security reserves in the form of time certificates of deposit, irrevocable standby letters of credit, or surety bonds naming CalOptima Health as beneficiary, equal to fifty-thousand dollars ($50,000) plus a minimum of twenty-five percent (25%) of one (1) month's average Capitation Payment, typically computed at the end of each quarter. CalOptima Health may require a greater amount based upon its assessment of the operational readiness and financial condition of the Primary Physician Group, Primary Hospital, or SRG. If the entity meets the fifty thousand dollars ($50,000) element of the financial security reserve requirement for participation as a contract holder with CalOptima Health for OneCare Members, the entity shall be deemed to have met the fifty-thousand dollars ($50,000) element of the financial security reserve requirement for Medi-Cal.

2. Capitation Payment Withhold - CalOptima Health shall withhold from each Health Maintenance Organization (HMO), Primary Physician Group, Primary Hospital, and SRG an amount equal to twenty-five percent (25%) of a monthly Capitation Payment, typically computed at the end of each quarter. CalOptima Health may adjust the Capitation Payment each quarter to reflect twenty-five percent (25%) of the current month's Capitation Payment. CalOptima Health may increase this withhold rate based upon its assessment of the operational readiness and financial condition of the HMO, Primary Physician Group, Primary Hospital, or SRG.

3. An HMO contracted on a capitated basis to provide Covered Services to Members shall retain at all times a valid Knox-Keene license issued by the California Department of Managed Health Care (DMHC). CalOptima Health shall waive financial security reserves required for an HMO should the HMO meet the statutory requirement and maintain required Tangible Net Equity (TNE) in accordance with Title 28, California Code of Regulations, Section 1300.76.

III. PROCEDURE

A. Health Network Reporting of Financial Information

1. A Health Network shall report financial information to CalOptima Health on a quarterly and annual basis in accordance with CalOptima Health Policy FF.3001: Financial Reporting.

2. A Health Network shall report immediately to CalOptima Health any event that materially alters the Health Network's financial situation or threatens its solvency, pursuant to Title 28, California Code of Regulations; Sections 1300.75.4 through 1300.75.4.8. In such instances, CalOptima Health may require monthly reporting until such time that the Health Network's solvency is no longer in question.

B. CalOptima Health Review of Financial Information

1. CalOptima Health shall review a Health Network's Financial Statements and other financial information on a quarterly and annual basis to evaluate the data, trend indicators for the Health Network, and compare similar indicators between Health Networks including:

   a. Current ratio (must be greater than 1.0);

   b. Cash to claims ratio (must be greater than 0.75);

   c. Tangible Net Equity (TNE) (must be positive);

   d. Operating cash and equivalents position;

   e. Medical claims liability;

   f. Incurred But Not Reported (IBNR) claims;

   g. Debt to equity ratio;

   h. Excess of revenues over expenses;

   i. Medical Loss Ratio (MLR); and

   j. Administrative cost percentage.

2. CalOptima Health shall ensure that an HMO and a Risk Bearing Organization (RBO) complies with the DMHC TNE and fiscal solvency requirements by:

    a. Reviewing the HMO's Orange Blank filings;

    b. Reviewing the HMO's and RBO's audited Financial Statements and other reports submitted quarterly and annually to DMHC; and

    c. Making appropriate inquiries of the HMO's and RBO's key financial personnel during any review.

3. CalOptima Health shall ensure that a contracting Health Network is in compliance with CalOptima Health fiscal solvency requirements by determining if it has established and maintained Financial Solvency Reserves in accordance with the provisions in this policy.

C. CalOptima Health Monitoring of Financial Solvency Reserves

1. Each entity contracted as a Primary Physician Group, Primary Hospital, or SRG shall establish financial security reserves in the form of Financial Security Instruments, as described in Section II.B.1.

    a. The Financial Security Instruments, in the form of time certificates of deposit, irrevocable standby letters of credit or surety bonds, shall designate CalOptima Health as the sole beneficiary for the duration of the Primary Physician Group, Primary Hospital, or SRG's participation in the CalOptima Health program. CalOptima Health shall access these funds only in the event such funds are needed to protect the interests of and ensure the continuation of Covered Services to Members, or for administrative costs directly attributed to a conservatorship, receivership, or liquidation.

    b. The Financial Security Instruments shall require the signature of an authorized CalOptima Health Officer in order to withdraw or transfer funds.

    c. CalOptima Health shall monitor the financial security reserves and review their adequacy quarterly.

    d. In the event the monthly Capitation Payments to a Primary Physician Group, Primary Hospital, or SRG materially increase due to membership or rate increases, CalOptima Health shall inform the Primary Physician Group, Primary Hospital, or SRG in writing that an increase in financial security reserves is required.

    e. CalOptima Health shall not grant an adjustment to the financial security reserves for decreased monthly Capitation Payments to the Primary Physician Group, Primary Hospital, or SRG unless the decrease is material and only upon receiving a formal written request from the Primary Physician Group, Primary Hospital, or SRG.

    f. In the event a Primary Physician Group, Primary Hospital, or SRG requests a substitution of a Financial Security Instrument, they shall submit the new Financial Security Instrument to CalOptima Health. CalOptima Health shall not release the old Financial Security Instrument prior to the receipt of the new Financial Security Instrument.

    g. Release of Financial Security Reserves upon Health Network Termination

i. CalOptima Health shall release a Financial Security Instrument no earlier than six (6) months following a Primary Physician Group, Primary Hospital, or SRG's termination in the CalOptima Health program unless the termination is the result of the Primary Physician Group, Primary Hospital, or SRG's insolvency, in which case CalOptima Health shall release a Financial Security Instrument no earlier than twelve (12) months following a Primary Physician Group, Primary Hospital, or SRG's termination in the CalOptima Health program. Release shall only occur after the Primary Physician Group, Primary Hospital, or SRG has met all operational requirements.

ii. CalOptima Health shall inform the Primary Physician Group, Primary Hospital or SRG, in writing, of the expected date CalOptima Health will release a Financial Security Instrument following the Health Network's termination in the CalOptima Health Medi-Cal program.

2. CalOptima Health shall establish a Capitation Payment withhold for a Health Network.

a. CalOptima Health shall monitor Capitation Payment withholds and review their adequacy quarterly as described in Section II.B.2.

b. In the event the monthly Capitation Payments to a Health Network materially increase due to membership or rate increases, CalOptima Health shall inform the Health Network in writing that an increase in Capitation withhold is required and shall deduct the additional withhold amount in a future Capitation Payment.

c. In the event the monthly Capitation Payments to a Health Network materially decrease due to membership or rate decreases, CalOptima Health shall release the Capitation Payment withhold surplus to the Health Network in a future Capitation Payment.

d. Release of the Capitation Payment Withhold upon Health Network Termination

i. CalOptima Health shall release a Capitation Payment withhold not earlier than nine (9) months after a Health Network's termination in the CalOptima Health program unless the termination is the result of the Health Network's insolvency, in which case CalOptima Health shall release a Capitation Payment withhold no earlier than twelve (12) months following Health Network's termination in the CalOptima Health program. Release shall only occur after the Health Network has met all operational requirements.

ii. CalOptima Health shall inform the Health Network in writing of the expected date CalOptima Health will release a Capitation Payment withhold following the Health Network's termination in the CalOptima Health program.

D. CalOptima Health Summary and Reporting of Findings

1. CalOptima Health shall prepare summaries of the following:

a. Financial ratios and other financial elements by Health Network, trended quarterly;

b. Financial security reserves; and

c. Capitation Payment withhold amounts.

2. CalOptima Health shall utilize the summaries described in Section III.D.1 of this Policy to:

a. Monitor the financial position of a Health Network during the Health Network financial review process; and

b. Assess Health Network compliance on an ongoing basis.

3. CalOptima Health shall summarize and report the results of any financial review and Focused Review to the Health Network, the Audit and Oversight Committee, CalOptima Health executive management, and CalOptima Health Finance & Audit Committee (FAC), as needed.

E. Corrective Action and Sanctions

1. If a Health Network fails to comply or meet any of the standards or requirements outlined in this policy, CalOptima Health may take the following actions:

a. Require a Health Network to submit a Corrective Action Plan (CAP) as appropriate, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

b. Place the Health Network in a contractual cure for breach of contract, including the following:

i. CalOptima Health may seize any Capitation and/or monies owed and place the Health Network under financial supervision until breach is cured. Financial supervision to include:

a) Withholding of monthly Capitation; and

b) Managing and releasing withheld Capitation to the Health Network to fund administrative expenses, Primary Care Provider (PCP) Capitation Payments and/or claims payments (limited specifically to months/dates of service that such withheld Capitation was intended to be used for payment);

ii. CalOptima Health may review the Health Network's financial statements, bank statements, and/or other records to ensure payments are made.

2. CalOptima Health may impose Sanctions in accordance with CalOptima Health Policy HH.2002: Sanctions.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. Contract for Health Care Services
C. CalOptima Health Policy FF.3001: Financial Reporting
D. CalOptima Health Policy HH.2002: Sanctions
E. CalOptima Health Policy HH.2005: Corrective Action Plan
F. Title 10, California Code of Regulations (C.C.R), § 1300.76
G. Title 22, California Code of Regulations (C.C.R), § 51301 *et seq.*
H. Title 28, California Code of Regulations (C.C.R), §§ 1300.75.4 through 1300.75.4.8

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/07/2016	Department of Health Care Services (DHCS)	Approved as Submitted
06/26/2023	Department of Health Care Services (DHCS)	Approved as Submitted

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)
Effective	01/01/2007	FF.3002	Financial Oversight	Medi-Cal
Revised	01/01/2008	FF.3002	Financial Oversight	Medi-Cal
Revised	02/01/2016	FF.3002	Financial Oversight	Medi-Cal
Revised	03/01/2017	FF.3002	Financial Oversight	Medi-Cal
Revised	07/01/2018	FF.3002	Financial Oversight	Medi-Cal
Revised	06/04/2020	FF.3002	Financial Oversight	Medi-Cal
Revised	08/01/2021	FF.3002	Financial Oversight	Medi-Cal
Revised	05/01/2022	FF.3002	Financial Oversight	Medi-Cal
Revised	07/01/2023	FF.3002	Financial Oversight	Medi-Cal
Revised	08/01/2024	FF.3002	Financial Oversight	Medi-Cal

IX. GLOSSARY

Term	Definition
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.
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.
Capitation Rate	The per capita rate set by CalOptima Health for the delivery of Covered Services to Members 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), a physician group under a shared risk contract, or HMO, and DHCS Medi-Cal Managed Care Division Policy Letters. .
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
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;

Term	Definition
	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); 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

Term	Definition
	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.
Department of Managed Health Care (DMHC)	The State Agency responsible for licensing and regulating health care services plans/health maintenance organizations in accordance with the Knox Keene Health Care Service Plan Act of 1975 as amended.
Financial Solvency Reserves	Funds comprised of security reserves and/or capitation withhold that are required for the duration of a Physician Hospital Consortium's (PHC)'s, Shared Risk Group's (SRG)'s, or Health Maintenance Organization's (HMO) participation in the CalOptima Health program. These funds are used to protect the interests of and ensure the continuation of health care services to the Members assigned to the PHC, SRG or HMO; they may also be used for administrative costs directly attributable to a conservatorship, receivership or liquidation.
Financial Statement	For purposes of this policy, reports prepared by an entity such as a Health Network to present its financial performance and position at a point in time, and include a balance sheet, income statement, statement of cash flows, statement of equity and accompanying footnotes prepared in accordance with Generally Accepted Accounting Principles (GAAP).
Financial Security Instrument	Time certificate of deposit, irrevocable standby letter of credit, or surety bond naming CalOptima Health as the beneficiary.
Focused Review	An audit that specifically targets areas of potential deficiency.
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	For the purposes of this policy, 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, either directly or through the use of subcontractors and downstream subcontractors that may be subject to the terms of this policy.
Incurred But Not Reported (IBNR)	An estimate of claims that have been incurred for medical services provided, but for which claims have not yet been received by the Health Network.
Knox-Keene Health Care Services Plan Act of 1975 (Knox-Keene)	The law that regulates HMOs and is administrated by the Department of Managed Health Care (DMHC), commencing with Section 1340 of the California Health and Safety Code.
Medical Loss Ratio (MLR)	The percentage calculated by dividing the Health Network's total medical costs paid on behalf of CalOptima Health Members by the total revenue received from CalOptima Health. Health Network medical costs would include payments to physicians (i.e. capitation, fee-for-service, or salary), medical groups/ independent practice Associations (IPAs), hospitals, labs, ambulance companies, and other providers of service.
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 Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.

Term	Definition
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).
Provider	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Risk Bearing Organization (RBO)	A professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, or another lawfully organized group of physicians that: 1. Delivers, furnishes, or otherwise arranges for or provides health care services; and 2. Does all the following: a. Contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees; b. Receives compensation for those services on a capitated or fixed periodic payment basis; and c. Is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of a health care service plan that are covered under the capitation payment made by the plan to the risk bearing organization.
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, CalOptima Health policy, or other requirements related to CalOptima Health programs.
Shared Risk Group (SRG)	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.
Tangible Net Equity (TNE)	Net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with non-affiliates and which are not past due; long term prepayments of deferred charges, and non-returnable deposits.