Policy:	FF.1001
Title:	**Capitation Payments**
Department:	Finance
Section:	Accounting
CEO Approval:	*/s/ Michael Hunn 05/23/2024*
Effective Date:	01/01/2007
Revised Date:	05/01/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes a process for CalOptima Health to remit timely and accurate Capitation Payments to a Health Network.

II. POLICY

A. Capitation Payment

1. CalOptima Health shall pay a Capitation Payment to a Health Network in accordance with the Contract for Health Care Services and the provisions set forth in this Policy.

2. 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).

3. Section II.B, Section III.B, and III.C. of this Policy related to Capitation Rates for Acquired Immune Deficiency Syndrome (AIDS) and End Stage Renal Disease (ESRD) shall not apply to Kaiser Foundation Health Plan (Kaiser).

4. CalOptima Health shall pay a Capitation Payment to a Health Network for Members who are eligible for services under the California Children's Services (CCS) Program in accordance with the Health Network's Contract for Health Care Services, the CalOptima Health Board of Directors (BOD)-approved payment methodology, and the terms and conditions of CalOptima Health Policy FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks.

    a. In the event a CCS-eligible Member meets the ESRD qualification criteria set forth in Section II.B.2.a of this Policy, CalOptima Health may make a Capitation Payment to the Member's Health Network at the ESRD Capitation Rate in accordance with the provisions set forth in this Policy.

    b. CalOptima Health shall end this Section II.A.4. with the same end date documented on CalOptima Health Policy FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks. Thereafter, CalOptima Health shall pay for CCS Members in accordance with other sections of this Policy.

B. Capitation Rate for AIDS or ESRD

1. CalOptima Health may make a Capitation Payment to a Health Network at the AIDS Capitation Rate for an eligible Member in accordance with the Contract for Health Care Services and the provisions set forth in this Policy.

    a. A Health Network may receive Capitation Payment at the AIDS Capitation Rate for a Member who:

        i. Is twenty-one (21) years of age, or older;

        ii. Has a confirmed diagnosis of AIDS, consistent with the current definition adopted by the Federal Centers for Disease Control and Prevention (CDC); and

        iii. Has such diagnosis formally recorded, dated, and signed by a treating physician in the Member's Medical Record.

    b. To receive a Capitation Payment at the AIDS Capitation Rate, a Health Network shall submit Human Immunodeficiency Virus (HIV)/AIDS Quality Indicators to CalOptima Health within the time frame set forth in this Policy.

    c. A Health Network shall notify CalOptima Health of a change in an eligible Member's status within the time frame set forth in this Policy.

2. CalOptima Health may make a Capitation Payment to a Health Network at the ESRD Capitation Rate for an eligible Member in accordance with the Contract for Health Care Services and the provisions set forth in this Policy.

    a. A Health Network may receive Capitation Payment at the ESRD Capitation Rate for a Member who:

        i. Has a confirmed diagnosis of ESRD; and

        ii. Has begun a regular course of dialysis that is formally recorded, dated, and signed by a treating physician and documented in the Member's Medical Record.

    b. Upon notice, CalOptima Health shall transition an eligible Member to CalOptima Health Direct (COHD) in accordance with CalOptima Health Policy DD.2006: Enrollment In/Eligibility with CalOptima Health Direct.

    c. To receive a Capitation Payment at the ESRD Capitation Rate, a Health Network shall submit documentation for an eligible Member within the time frame set forth in this Policy.

    d. A Health Network shall notify CalOptima Health of a change in an eligible Member's status within the time frame set forth in this Policy.

    e. CalOptima Health shall recoup payments made to a Health Network if CalOptima Health determines by subsequent Encounter data review, or a clinical review, that a Member for whom CalOptima Health made a Capitation Payment at the ESRD Capitation Rate did not meet administrative, or clinical, requirements as defined herein.

3. Except as provided in Section II.B.2.b. of this Policy, if a Member meets both the criteria for the AIDS Capitation Rate, as set forth in Section II.B.1.a. of this Policy and criteria for the ESRD

Capitation Rate, as set forth in Section II.B.2.a. of this Policy, CalOptima Health shall make a Health Network Capitation Payment for such Member at the ESRD Capitation Rate.

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

D. 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.

E. CalOptima Health may adjust Capitation Rates during the contract period.

F. Notwithstanding anything to the contrary contained in the Contract for Health Care Services, or this Policy, CalOptima Health's obligation to render payments shall be subject to CalOptima Health's receipt of funding from the State of California.

G. A Health Network shall report any and all disputes related to payment or enrollment, except as specified in Section II.D. of this Policy, in writing, to CalOptima Health's Accounting Department within ninety (90) calendar days after receipt of payment. Failure to dispute within the established time frame indicates acceptance by the Health Network and a waiver of its right to dispute.

III. PROCEDURE

A. Capitation Payment

1. CalOptima Health shall pay a Capitation Payment to only one (1) Primary Physician Group and one (1) Primary Hospital of a Physician Hospital Consortium (PHC), one (1) Shared Risk Group (SRG), or one (1) Health Maintenance Organization (HMO) for enrolled Members covered by the Health Network.

    a. The Primary Physician Group and Primary Hospital of a PHC, SRG, or HMO receiving the Capitation Payment shall ensure compliance with CalOptima Health's financial security requirements as set forth in CalOptima Health Policy FF.3002: Financial Oversight.

    b. A Health Network shall handle subsequent payments internally for any sub-capitation, or other subcontractor arrangements.

2. CalOptima Health shall pay the Capitation Payment on, or about, the fifteenth (15th) calendar day of the month to which Capitation Payment applies.

3. 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.

4. Within three (3) working days of check issuance, the CalOptima Health Information Services (IS) 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. Acquired Immune Deficiency Syndrome (AIDS) Capitation Rate

1. CalOptima Health shall make a Health Network Capitation Payment at the AIDS Capitation Rate for a Member who meets criteria as set forth in Section II.B.1.a. of this Policy effective the month in which the confirmed diagnosis of AIDS is made for the Member and reported to CalOptima Health.

2. A Health Network shall submit a copy of a Member's Medical Record with the confirmed diagnosis of AIDS to the CalOptima Health, Health Network Relations Department as notification that the Health Network is eligible to receive a Capitation Payment at the AIDS Capitation Rate for such Member.

    a. A Health Network shall submit a copy of the eligible Member's Medical Record with the confirmed diagnosis of AIDS no later than sixty (60) calendar days after the date of the confirmed diagnosis of AIDS.

    b. CalOptima Health shall make a Health Network Capitation Payment at the AIDS Capitation Rate for an eligible Member on a daily prorated basis with retroactivity up to sixty (60) calendar days from the date CalOptima Health receives such Member's Medical Record with the confirmed diagnosis of AIDS.

    c. If a Health Network submits an eligible Member's Medical Record with the confirmed diagnosis of AIDS within sixty (60) calendar days after the date the Member received a confirmed diagnosis of AIDS, the Health Network shall receive a Capitation Payment at the AIDS Capitation Rate effective the date such Member received a confirmed diagnosis of AIDS.

    d. If a Health Network submits an eligible Member's Medical Record with the confirmed diagnosis of AIDS after sixty (60) calendar days have passed from the date the Member received a confirmed diagnosis of AIDS, the Health Network shall receive a Capitation Payment at the AIDS Capitation Rate effective sixty (60) calendar days prior to CalOptima Health's receipt of such Member's Medical Record with the confirmed diagnosis of AIDS, and shall not receive that rate for any time period before such effective date.

3. Subject to the provisions of this Policy, a Health Network shall receive a Capitation Payment at the AIDS Capitation Rate for an eligible Member for whom a Health Network has submitted a Medical Record with a confirmed diagnosis of AIDS until the Health Network reports a status change for the Member.

4. A Health Network shall notify CalOptima Health's Health Network Relations Department, in writing, of a change in the status of an eligible Member by the twenty-fifth (25^{th}) calendar day of each month. A change in the status of an eligible Member status includes, but is not limited to, death.

C. ESRD Capitation Rate

1. A Member's dialysis center and treating physician shall complete a Form CMS 2728-U3 and report a Member with ESRD to a national ESRD patient registry established by Title XVIII, Section 1881 of the Social Security Act. The Member's dialysis center, or dialysis training facility, shall maintain Form CMS-2728-U3.

2. A Health Network shall submit a copy of Form CMS-2728-U3 to the CalOptima Health, Health Network Relations Department as notification that the Member is eligible for enrollment in CalOptima Health Direct in accordance with CalOptima Health Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.

    a. If CalOptima Health receives Form CMS-2728-U3 for a Member from a Health Network on, or before, the fifteenth (15th) calendar day of the month, CalOptima Health shall make a Capitation Payment at the ESRD Capitation Rate for the Member for the month that CalOptima Health received Form CMS-2728-U3 and any subsequent months until CalOptima Health transitions the Member into CalOptima Health Direct. For example, if CalOptima Health receives Form CMS-2728-U3 from a Health Network on, or before, June 15, CalOptima Health shall make a Capitation Payment at the ESRD Capitation Rate for the month of June.

    b. If CalOptima Health receives Form CMS-2728-U3 for a Member from a Health Network after the fifteenth (15th) calendar day of the month, CalOptima Health shall make a Capitation Payment at the ESRD Capitation Rate for the Member for the month following the date that CalOptima Health received Form CMS-2728-U3, and any subsequent months until CalOptima Health transitions the Member into CalOptima Health Direct. For example, if CalOptima Health receives Form CMS-2728-U3 from a Health Network on or after June 16, CalOptima Health shall not make a Capitation Payment at the ESRD Capitation Rate for the month of June. CalOptima Health shall make a Capitation Payment at the ESRD Capitation Rate for the month of July.

3. CalOptima Health's Case Management Department may conduct a clinical review of a Member whose ESRD status is unclear to determine if such Member meets the criteria as set forth in Section III.C.2.a. of this Policy.

IV. ATTACHMENT(S)

A. End Stage Renal Disease Medical Evidence Report - Medicare Entitlement and/or Patient Registration (Form CMS-2728-U3 [11/23])

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Contract for Health Care Services
C. CalOptima Health Policy DD.2006: Enrollment In/Eligibility with CalOptima Health Direct
D. CalOptima Health Policy FF.3002: Financial Oversight
E. CalOptima Health Policy FF.4000: Whole-Child Model – Financial Reimbursement for Capitated Health Networks
F. Department of Health Care Services (DHCS) All Plan Letter 23-011: Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Providers (Supersedes APL 17-003)
G. Title XVIII, Social Security Act, Section 1881
H. Title 42, Code of Federal Regulations (C.F.R), §438.608(d)(2)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/14/2011	Department of Health Care Services (DHCS)	Approved as Submitted
06/09/2017	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
06/03/2008	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	01/01/2007	FF.1001	Capitation Payments	Medi-Cal
Revised	07/01/2008	FF.1001	Capitation Payments	Medi-Cal
Revised	01/01/2011	FF.1001	Capitation Payments	Medi-Cal
Revised	09/01/2014	FF.1001	Capitation Payments	Medi-Cal
Revised	01/01/2017	FF.1001	Capitation Payments	Medi-Cal
Revised	07/01/2017	FF.1001	Capitation Payments	Medi-Cal
Revised	01/01/2019	FF.1001	Capitation Payments	Medi-Cal
Revised	03/01/2019	FF.1001	Capitation Payments	Medi-Cal
Revised	07/01/2019	FF.1001	Capitation Payments	Medi-Cal
Revised	06/04/2020	FF.1001	Capitation Payments	Medi-Cal
Revised	07/01/2021	FF.1001	Capitation Payments	Medi-Cal
Revised	05/01/2022	FF.1001	Capitation Payments	Medi-Cal
Revised	07/01/2023	FF.1001	Capitation Payments	Medi-Cal
Revised	05/01/2024	FF.1001	Capitation Payments	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.
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	For the purposes of this policy, the written instrument between CalOptima Health and a Physician Hospital Consortium (PHC), Shared Risk Group (SRG), Health Maintenance Organization (HMO), or other entity, for the purpose of providing delegated services to assigned Members. Contract shall include any Memoranda of Understanding entered into by CalOptima Health that is binding on the PHC, SRG, or HMO; DHCS Medi-Cal Managed Care Division All Plan and Policy Letters; and Contract Interpretation.
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.
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.
End Stage Renal Disease (ESRD)	That stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. End Stage Renal Disease is classified as Stage V of Chronic Kidney Disease. This stage exists when renal function, as measured by glomerular filtration rate (GFR), is less than 15ml/min/1.73m2 and serum creatinine is greater than or equal to eight, unless the Member is diabetic, in which case serum creatinine is greater than or equal to six (6). Excretory, regulatory, and hormonal renal functions are severely impaired, and the Member cannot maintain homeostasis.
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.

Term	Definition
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima Health policy.
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.
Physician Hospital Consortium (PHC)	A Physician Group or Physician Groups contractually aligned with at least one (1) hospital to provide Medi-Cal services to a common set of assigned Members, as described in CalOptima Health's Contract for Health Care Services.
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).
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, as of a specified date in the past, is no longer eligible for benefits under the specified CalOptima Health program.
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.