
19. FINANCE AND REIMBURSEMENT

A. IPA Financial Viability

APPLIES TO:

- A. This policy applies to all IPAs participating in the IEHP DualChoice ~~line of business Cal MediConnect Plan (Medicare—Medicaid Plan) product line contracted with IEHP.~~

POLICY:

- A. IEHP complies with all regulatory requirements to protect its Members and Providers from the consequences of financial failure of an IEHP-contracted IPA.
- B. IEHP monitors the financial viability of all contracted IPAs and has established funding requirements to ensure all contracted IPAs are financially sound and can handle the risks associated with capitation.
- C. IEHP requires all contracted IPAs to meet IEHP's and California Department of Managed Health Care's (DMHC) financial viability standards/requirements for Risk ~~B~~bearing Organizations (RBOs) ~~as stated within the California Code of Regulations Title 28 §1300.75.4.2~~ prior to Member assignment to the IPA's Primary Care Providers (PCPs) and on an ongoing basis.¹

PROCEDURES:

- A. Prior to entering into a contractual agreement with IEHP and annually thereafter, IPAs must submit their most current audited financial statements, and their most recent monthly and year-to-date financial statements comprising Balance Sheets, Income Statements, Cash Flow Statements and supporting worksheets for incurred, but not reported (IBNR) or IBNR certification by an independent, certified actuary mutually acceptable to IEHP. Additionally, the IPA must submit their required periodic financial and organizational information disclosures ~~as stated in section 1300.75.4.2 of Title 28 California Code of Regulations~~ as an RBO within five (5) business days after the due date.² The financial statements must demonstrate that the IPA is financially viable and is able to meet IEHP's and DMHC's financial viability standards/requirements as referenced above. IEHP does not contract with IPAs that do not meet these standards.
- B. On an ongoing basis, all contracted IPAs are required to submit to IEHP a copy of their financial statements comprising Balance Sheets, Income Statements, Cash Flow Statements and supporting worksheets for IBNR on a quarterly basis within forty-five (45) days of the end of each calendar quarter. Additionally, the IPA must submit their required periodic financial and organizational informational disclosures as stated in section 1300.75.4.2 of Title 28 California Code of Regulations as an RBO within five (5) business days after the due date.³

¹ Title 28 California Code of Regulations (CCR) §1300.75.4.2

² Ibid.

³ ~~28 CCR §1300.75.4.2 Ibid~~Ibid.

19. FINANCE AND REIMBURSEMENT

A. IPA Financial Viability

When requested, IPAs shall also provide written explanation within two (2) weeks substantiating any of the following (but not limited to):

1. Cash & Cash Equivalents including Restricted Assets
 2. All Receivables – Current and Long Term
 3. All Liabilities – Current and Long Term, including IBNR
 4. Any Due To/From Shareholders/Partnership
 5. Any Intercompany or Related Transaction
 6. Revenues
 7. Medical Expenditures
 8. General and Administrative Expenditures
- C. On an annual basis, all contracted IPAs are required to submit annual audited financial statements, including IBNR certification to IEHP for compliance review no later than ~~one one hundred~~ one hundred-fifty (150) days after the end of the IPA's fiscal year. Additionally, the IPA must submit their required periodic financial and organizational informational disclosures ~~as stated in section 1300.75.4.2 of Title 28 California Code of Regulations~~ as an RBO within five (5) business days after the due date.⁴
- D. Financial statements must clearly display the financial condition of the entity that holds the contract with IEHP. Submission of related party, affiliate, consolidated or parent company financials are not acceptable. Consolidating financial statements are only acceptable if the financial condition of the IEHP contracted entity is clearly documented and identified. Consolidating financial statements must clearly identify any inter-company transactions between related parties, affiliates, or parent company.
- E. IEHP will review the financial statements submitted by the IPAs to ensure the following IEHP financial viability standards/requirements are always met:
1. Maintained a positive Tangible Net Equity (TNE) ~~as defined in section 1300.76 of the Title 28 California Code of Regulations.~~⁵
 2. Maintained a positive working capital calculated in a manner consistent with Generally Accepted Accounting Principles (GAAP).
 3. The Current Ratio (the ratio of current assets to current liabilities) always exceeds 100%.
 4. Quick ratio is always greater than 1.0.
 5. Debt Coverage Multiple is always greater than 1.2.
 6. Cash to Claims Ratio is always 0.75 or greater.

⁴ 28 CCR §1300.75.4.2

⁵ 28 CCR §1300.76

19. FINANCE AND REIMBURSEMENT

A. IPA Financial Viability

7. Medical Expense Ratio is always less than ~~0.89~~;0.89.
 8. The plan must be notified if claims payable days outstanding is more than four (4) months
 9. The plan must be notified if accounts receivable days outstanding is more than sixty (60) ~~days~~;days.
 10. Total Assets, (Net of Intangibles and/or Due from Officers, Directors, and Affiliates) as reported on the financial statements, shall fully fund Incurred But Not Reported (IBNR) ~~claims~~;claims.
 11. IBNR calculation worksheets that support the amounts represented on the financial statements accompany all submissions. IPAs must also provide the following:
 - a. The methodology used to calculate IBNR
 - b. The data and work papers to substantiate IBNR
 - c. Independent review and certification, if necessary, by:
 - 1) IEHP
 - 2) -IPA's Actuary
- F. If for any reason the IPA's Medical Expense ratio is above 0.89, as set forth in section E.7 of this policy, then the following will be required of the IPA:
1. Medical Expense Ratio greater than 0.89, up to 0.95 - IPA must submit monthly claim lag tables.
 2. Medical Expense Ratio greater than 0.95 - IPA must submit the following documentation:
 - a. -Requirement noted above (in section F.1)
 - b. As well as a monthly income statement with detailed explanations of the nature of the deficiency, the reasons for the deficiency, and any actions taken to correct the deficiency within fifteen (15) days of month-end close; and
 - c. Increase the Letter of Credit (LOC) on file by the deficiency amount of the TNE.
- G. IEHP reserves the right to request additional detailed work papers supporting account balances represented on the IPA's or Management Service Organization's (MSO) financial statements.
- H. IEHP reserves the right to ask for more frequent financial reports and information upon written notice to the IPA and making appropriate inquiries of the IPA's key financial personnel during any review.
- I. IEHP reserves the right to approve or deny use of a particular MSO by the IPA.
- J. All contracted IPAs shall also have the ability to secure an Irrevocable Standby LOC (See Attachment, "Irrevocable Letter of Credit" in Section 19), with IEHP as the beneficiary, prior

19. FINANCE AND REIMBURSEMENT

A. IPA Financial Viability

to receiving Member enrollment, and quarterly thereafter.⁶ This requirement will be waived for IPAs having a Limited Knox-Keene license.

- K. The LOC secured amounts generally are linked to the IPA's combined ownership of IEHP enrollment as follows:

IPA's enrollment	Deposit Requirement
Up to - 10,000	\$100,000.00
10,001 - 20,000	\$200,000.00
20,001 -30,000	\$300,000.00
30,001 - 40,000	\$400,000.00
40,001 - 50,000	\$500,000.00
50,001 – 60,000	\$600,000.00
60,001 – 70,000	\$700,000.00
70,001 – 80,000	\$800,000.00
80,001 – 90,000	\$900,000.00
90,001 plus	\$1,000,000.00

- L. Enrollment levels will be reviewed at the end of the reporting quarter, and LOC deposit amounts adjusted, as applicable, within thirty (30) days after the end of the reporting quarter.
- M. In addition to securing an Irrevocable Standby LOC with IEHP as the beneficiary, IPAs are also required to establish a restricted cash reserve in the amount of 25% of the average monthly capitation revenue for the reporting quarter. This requirement will be waived for IPAs having a Limited Knox-Keene license.
- N. In order to satisfy the restricted cash reserve requirement, IPAs have the following options:
1. Secure an Irrevocable Standby LOC designating IEHP as the beneficiary.
 2. Elect to have the monthly IPA capitation revenue adjusted by IEHP.
- O. IEHP reserves the right to increase the LOC amount for a IPA failing to meet TNE requirements by the amount the IPA is deficient, which may be in addition to the deposit required based on enrollment.
- P. IEHP reserves the right to increase the LOC amount for an IPA based on either the enrollment level or IBNR, whichever one is higher.
- Q. Letters of Credit (~~LOC~~) backed by an agreed upon future loan from a financial institution will require the IPA to submit a complete list of all LOCs on record with other Health Plan

⁶ International Standby Practices 1998, ICC Publication No. 590

19. FINANCE AND REIMBURSEMENT

A. IPA Financial Viability

organizations. These LOCs should also be clearly listed and described in the notes to the financial statements.

- R. Letters of Credit backed by funds deposited within a secured location such as a financial institution must remain in place for the entire contract year and for one hundred eighty (180) days after the contract expiration/termination.
- S. If the IPA fails to meet any of the above referenced standards, IEHP may take the following actions:
1. Freeze the IPA to new membership;
 2. Place the IPA in a contractual cure for breach of contract;
 3. Seize any capitation and/or monies owed and place the IPA under Financial Supervision until breach is cured; ~~and~~
 - a. Financial Supervision to include:
 - 1) Withholding of monthly capitation
 - 2) Managing and releasing withheld capitation to the IPA to fund:
 - Administrative Expenses
 - PCP Capitation Payments
 - Claims Payments - limited specifically to months/DOS withheld capitation was intended. ~~for payment~~
 - 3) Reviewing financial statements, bank statements and/or other records to ensure payments are made. ~~payment~~
 4. Immediately terminate the IEHP/ IPA Agreement for cause.
- T. In the event an IPA fails to perform a financial covenant of its IEHP contract, IEHP may exercise its ability to draw down on the deposit or line of credit for its full amount.
- U. The above procedures, including LOC Requirements, may be adjusted by other factors that provide similar financial security as determined by the IEHP Chief Executive Officer or designee of the IEHP Chief Executive Officer.
- V. Upon request by IPA(s), at its sole discretion, IEHP may change/waive any/or part of the IPA Financial Viability Requirements as it deems necessary either globally or specific to an IPA.

19. FINANCE AND REIMBURSEMENT

A. IPA Financial Viability

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	January 1, 2007
Chief Title: Chief Operating <u>Financial</u> Officer	Revision Date:	January 1, 202 <u>3</u>

19. FINANCE AND REIMBURSEMENT

B. Medicare Capitation

1. IPA

APPLIES TO:

- A. This policy applies to all IEHP DualChoice, ~~Cal MediConnect Plan (Medicare-Medicaid Plan) or IEHP Dual Eligible Special Needs Plan (D-SNP)~~ Independent Physician Associations (IPAs).

POLICY:

- A. IEHP delegates the responsibility of providing medical services for its Members to its IPAs who are contracted with IEHP under a capitated arrangement. In exchange for these services IEHP makes monthly capitation payments to the IPA for their assigned Members ~~assigned to that organization~~.
- B. The amount of capitation is paid per contract on a percent of premium basis and is paid in full to the IPA for a specified list of services provided to an assigned Member. The list of services covered by capitation is described in the IEHP Capitated Agreement with the IPA.
- ~~C. Capitation is paid monthly to each IPA for all of their assigned Members. The payments are transferred via Electronic Funds Transfer (EFT) by the 16th day of each month and by the first day of each month following the month of service. Retroactive enrollment and disenrollment activities of assigned Members are automatically calculated and included in the monthly capitation payments.~~
- D. Capitation is only paid for Members with active eligibility at the end of the prior month as noted on the file received from the Centers for Medicare & Medicaid Services (CMS).
- E. It is the responsibility of the IPA to provide or arrange for services that are the financial responsibility of the IPA.

PROCEDURES:

- A. IEHP calculates capitation payments per the contract for each IPA based on the current (new) month's membership and any retroactive adjustments.
- B. Capitation payments are transferred via EFT to the IPA no later than the 16th day of each month for the month of service, and by the first of each month following the month of service. Retroactive enrollment and disenrollment activities of Members assigned to IPAs are automatically calculated and included in the monthly capitation payments.
- C. Each month IEHP creates a capitation file containing all of the detail information from the capitation reports. These files are placed on the Secure File Transfer Protocol (SFTP) server by the first of the month for the prior month's capitation, and by the 16th of the month for the mid-month capitation (~~for file format information—~~See Attachment "Capitation Data File Format" in Section 19 or refer to the IEHP Provider Electronic Data Interchange (EDI) Manual).

19. FINANCE AND REIMBURSEMENT

B. Medicare Capitation

1. IPA

~~D.~~—To reconcile the amount paid each month, IPAs should review the electronic cap files and capitation reports provided by IEHP (See Attachments, “Capitation Date File Format” in Section 19).

D.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	January 1, 2007
Chief Title: Chief Operating Officer	Revision Date:	January 1, 202 3 ²

19. FINANCE AND REIMBURSEMENT

B. Medicare Capitation

2. IEHP Direct Providers

APPLIES TO:

- A. This policy applies to all IEHP DualChoice, ~~Cal MediConnect Plan (Medicare-Medicaid Plan) or Medicare Dual Eligible Special Needs Plan (D-SNP)~~ Primary Care Provider (PCPs).

POLICY:

- A. IEHP delegates the responsibility of providing medical services for its Members to its Primary Care Providers (PCPs) who are contracted with IEHP under a capitated arrangement. In exchange for these services, IEHP makes monthly capitation payments to the PCPs for their assigned Members ~~assigned to that organization~~.
- B. The amount of capitation paid is based on the Medicare Hierarchical Condition Code (HCC) score and is paid in full to the PCP for a specified list of services provided to ~~an~~ their assigned Member. The list of services covered by capitation is described in the IEHP Capitated Agreement.
- ~~C. Capitation is paid monthly to each PCP/Medical Group for all of their assigned Members. The payments are sent or transferred via Electronic Funds Transfer (EFT) by the first day of each month following the month of service. Retroactive enrollment and disenrollment activities of assigned Members are automatically calculated and included in the monthly capitation payments.~~
- D. Capitation is only paid for Members with active eligibility at the end of the prior month as noted on the file received from the Centers for Medicare & Medicaid Services (CMS).
- E. It is the responsibility of the PCP to provide or arrange for services that are the financial responsibility of the PCP.

PROCEDURES:

- A. IEHP calculates capitation payments for each PCP based on the current (new) month's membership and any retroactive adjustments.
- B. Capitation payments are ~~sent or~~ transferred via EFT to the PCP no later than the first of each month following the month of service for all assigned Members. Retroactive enrollment and disenrollment activities of Members assigned to the PCP are automatically calculated and included in the monthly capitation payments.
- C. Each month IEHP creates capitation files containing all of the detail information. These files are accessible from the sSecure Provider Portal ~~Website~~ by the first of the month for the prior month's capitation.
- D. To reconcile the amount paid each month, PCPs should review the capitation reports provided by IEHP.

19. FINANCE AND REIMBURSEMENT

- B. Medicare Capitation
 - 2. IEHP Direct Providers
-

19. FINANCE AND REIMBURSEMENT

- B. Medicare Capitation
 - 2. IEHP Direct Providers
-

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	January 1, 2007
Chief Title: Chief Operating Officer	Revision Date:	January 1, 2023 ¹

19. FINANCE AND REIMBURSEMENT

C. Pay For Performance

1. Medicare DualChoice Annual Visit

APPLIES TO:

- A. This policy applies to all IEHP Direct DualChoice ~~Cal MediConnect Plan (Medicare—Medicaid Plan)~~ Members.

POLICY:

- A. The IEHP's **Pay for Performance (P4P) Medicare DualChoice Annual Visit Program** ~~was~~ is designed to increase the provision of preventive health services to IEHP Members as well as improve HEDIS® results to ensure that all IEHP DualChoice Members receive timely annual visits with an emphasis on review and management of chronic illness.
- B. IEHP Direct PCPs are automatically enrolled in ~~this~~ P4P programs upon completion of IEHP's credentialing process.

PURPOSE:

- A. To improve the quality of care to IEHP Members and increase compliance with California Department of Health Care Services (DHCS), Centers for Medicare & Medicaid Services (CMS) and HEDIS® requirements.
- B. To ensure proper reimbursement to IEHP Direct PCPs participating in Medicare DualChoice Annual Visit P4P Program.

PROCEDURES:

- A. **Medicare DualChoice Annual Visit P4P**
1. PCPs who are credentialed with IEHP Direct and participating in the IEHP DualChoice Program are eligible for ~~the~~ Medicare DualChoice Annual Visit component.
 2. Only PCPs who are assigned IEHP Direct DualChoice Members are eligible for the Medicare DualChoice Annual Visits P4P component.
- B. The PCP can only receive reimbursement for an active Member who is assigned to them on the date services are provided, unless otherwise specifically noted.
1. Participating IEHP Direct PCPs must record significant chronic diagnoses and document history and physical findings related to these diagnoses in the medial record.
 2. The Medicare_DualChoice Annual Visit form is available on the Member Eligibility Webpage. A copy of this form should be printed prior to the Member's visit.
 3. Participating IEHP Direct PCPs must review the "Diagnosis Review" sections of the Medicare DualChoice Annual Visit form. The conditions need to be confirmed, identified with the appropriate ICD code(s) and noted with its respective assessment/plan.

19. FINANCE AND REIMBURSEMENT

C. Pay For Performance

1. Medicare DualChoice Annual Visit

4. Participating IEHP Direct PCPs are paid \$200 per each annual visit completed for an eligible IEHP Direct DualChoice Member. The incentive is paid in addition to the PCP's fee for service visit reimbursement or their capitated PCP agreement.
5. Only one (1) exam per year qualifies for this incentive, regardless of if the IEHP DualChoice Member has had several PCPs and multiple exams.
6. Medicare DualChoice Annual Visits must only be submitted securely -via www.iehp.org using the appropriate form.
 - a. Member's significant conditions/diagnoses must be assessed in total at the annual visit. Accurate clinical documentation and ICD coding reflecting the Member's condition/diagnoses must be entered on the form, including appropriate assessments and plans.
 - b. Completed annual visit forms must be submitted online to IEHP within one hundred eighty (180) calendar days from the date of service and must meet IEHP's submission standards to qualify for the incentive.
 - c. Failure to submit completed forms within the required timeframes will result in denial of reimbursement. IEHP will not accept or reimburse initial paper submissions made via mail or fax except corrective resubmission only.
7. Reimbursements are made within thirty (30) working days of receipt of a complete Medicare DualChoice Annual Visit form submitted online.

B. P4P Reports

1. Providers can print summary remittance advice reports with each payment distribution (See Attachments, "Remittance Advice – Medicare DualChoice Annual Visit" in Section 19). To access Remittance Advice (RAs) online, log on to the secure site login at www.iehp.org.

C. P4P Audit Process

1. IEHP conducts on-going audits of P4P Providers for compliance with P4P requirements, including submission accuracy, completeness of forms and supporting documentation in the Member's medical record for submitted reimbursement.
2. Providers are notified in writing approximately two (2) weeks prior to the targeted audit date. ~~IEHP follows up with a phone call to schedule the audit.~~
3. IEHP provides the names of the Members' charts to pull two (2) days prior to the scheduled audit.
4. IEHP provides the Provider with written notice of the findings within thirty (30) days of the audit date. Providers have thirty (30) days to respond to the findings.

19. FINANCE AND REIMBURSEMENT

C. Pay For Performance

1. Medicare DualChoice Annual Visit

~~5. Providers not responding to Corrective Action Plan (CAP) requests are subject to removal from participation in P4P.~~

~~6.5.~~ Depending on the nature and severity of the findings and the Provider's response (including non-responses), IEHP may take, but are not limited to, the following actions against the Provider ~~up to and including, but not limited to:~~

- a. Recoupment of all or a portion of the incentives paid under P4P for services deemed inappropriately performed and reimbursed;
- b. Removal from participation in P4P;
- c. Referral to the Peer Review Subcommittee and/or IEHP's Fraud Prevention Committee; and/or
- d. Removal from participation in the IEHP network.

~~7.6.~~ Providers removed from P4P for non-response to CAP requests, or because of the severity of the findings, may appeal the removal decision by submitting a written appeal to IEHP.

~~8.7.~~ Providers removed from P4P may not re-apply for participation for six (6) months. Providers removed from P4P more than twice are prohibited from future participation.

D. P4P Appeals/Inquiries/Corrections

1. Providers with any appeals related to previously denied P4P reimbursements may contact the IEHP Provider Relations Team at (909) 890-2054 or (886) 223-4347 Monday – Friday 8:00 am to 5:00 pm PST. Provider may also file an appeal within one hundred and twenty (120) days from the claim determination date.
2. The rendering Provider must attach a cover letter clearly indicating the reason for the appeal or may complete the Provider Dispute Resolution request form that can be downloaded online at <https://iehp.org/en/providers/provider-resources?target=forms#FormsClaims>.
3. The Medicare DualChoice Annual Visits disputes or corrections should be submitted to:

Inland Empire Health Plan
Attention: Quality Informatics
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800

4. Required information must include the specific services the Provider is appealing or inquiring and the reason the appeal should be considered in the Comments Section of the Appeal form. Incomplete information may cause a delay in the resolution of the appeal or inquiry.

19. FINANCE AND REIMBURSEMENT

C. Pay For Performance

1. Medicare DualChoice Annual Visit

E. Future Changes to P4P Program

1. IEHP reserves the right to change any component of these Programs at any time.
2. All decisions regarding the rules, requirements and compensation under the Programs are at the sole discretion of IEHP.

19. FINANCE AND REIMBURSEMENT

C. Pay For Performance

1. Medicare DualChoice Annual Visit

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	January 1, 2007
Chief Title: Chief Operating Officer	Revision Date:	January 1, 2023

19. FINANCE AND REIMBURSEMENT

D. IPA Financial Supervision

APPLIES TO:

A. This policy applies ~~for to~~ all IPAs contracted with IEHP.

POLICY:

- A. IEHP complies with all regulatory requirements to protect its Members and Providers from the consequences of financial failure of an IEHP-contracted IPA.
- B. IEHP requires all contracted IPAs to meet IEHP's and California Department of Managed Health Care's (DMHC) financial viability standards/requirements for Risk Bearing Organizations (RBOs) ~~under section 1300.75.4.2 of Title 28 California Code of Regulations~~ prior to assignment of Members to the IPA's Primary Care Providers (PCPs) and on an ongoing basis.¹
- C. IEHP monitors the financial viability of all contracted IPAs and has established funding requirements to ensure all contracted IPAs are financially sound and can handle the risks associated with capitation.
- D. IEHP shall place IPAs under the financial supervision program in the event an IPA is in breach of its contract with IEHP due to non-compliance with IEHP's financial viability standards and/or with the above-mentioned California regulation requirements.

PROCEDURES:

- A. ~~For~~ IPAs failing to meet IEHP's financial viability standards ~~and/or with section 1300.75.4.2 of Title 28 California Code of Regulations~~ requirements, shall be required to complete a Corrective Action Plan (CAP).² The CAP shall include a timeline for when the IPA shall come into compliance with the financial viability requirements. IEHP shall place the IPA under Financial Supervision until breach is cured.
- B. IPAs under Financial Supervision due to contractual breach may be subject to any or all of following actions at IEHP's discretion:
 - 1. ~~Freeze-Freezing to of~~ new membership.
 - 2. Withholding of monthly capitation revenue and other monies owed to the IPA.
 - 3. Managing and releasing withheld capitation and other monies owed to the IPA to fund:
 - a. Administrative Expenses funded monthly as specified in the IPA/Management Services Organization (MSO) contract.
 - b. PCP Capitation Payments for IEHP enrollees funded monthly for the current capitation period based on submission of a check run.

¹ Title 28 California Code of Regulations (CCR) §1300.75.4.2

² Ibid.

19. FINANCE AND REIMBURSEMENT

D. IPA Financial Supervision

- c. Fee-For-Service (FFS) claims payments for professional services rendered to IEHP enrollees funded monthly or at other intervals to coincide with IPA check runs limited specifically to months/date-of-service (DOS) withheld capitation was intended for payment.
- d. Any other legitimate business expense subject to approval by IEHP.
- 4. Withdrawal of the funds available in the Standby Letter of Credit (LOC)
- 5. Immediate termination as stated in the IPA contract.
- C. Any exceptions to the above including the limitation for FFS payments to fund existing claims ~~run-out~~run out (IBNR) must be approved by IEHP.
- D. Any remaining funds resulting from the implementation of the Financial Supervision may be netted against any claims expenses paid by IEHP for that IPA.
- E. IEHP shall review financial and other statements, including bank statements and/or other records to ensure payments are made and checks have been cleared.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	July 1, 2012

19. FINANCE AND REIMBURSEMENT

D. IPA Financial Supervision

Chief Title: Chief Operating Officer	Revision Date:	January 1, 202 2 <u>3</u>
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Capitation Data File Format Element Descriptions

#	DATA ELEMENT	FORMAT	DESCRIPTION
1	Capitation Month	YYYYMM	Month capitation is being processed and paid.
2	Eligibility Month	YYYYMM	Eligibility month
3	Hospital Number		Hospital Number
4	Hospital Name		Hospital Name
5	IPA	AAA	IPA Code
6	IPA Name		IPA Name
7	Tax ID		Employer Identification Number
8	Provider Number		Provider Number
9	Provider Last Name		Provider Last Name
10	Provider First Name		Provider First Name
11	Member Last Name		Member Last Name
12	Member First Name		Member First Name
13	Member Middle Initial		Member Middle Initial
14	Member Number	12345678901234	This is the fourteen (14) digit IEHP assigned Member # (See note #14).
15	Member Age	999	Member Age
16	Member Aid Code	AA	Member's two (2) digit Aid Code (See note #16)
17	Member Gender	M or F or U	Member Gender
18	Member CIN	12345678X	The nine (9) digit alpha-numeric CIN # (See note #18)
19	Member SSN	123456789	This field consists of one of the following: SSN#, PSEUDO#, or CIN# (See note #19)
20	Member Group	AAA-AAA or Cal MediConnect	Member Group (See note #20)
21	Member Category of Aid		Member Category of Aid (See note #21)
22	Member DOB	YYYYMMDD	Member date of birth
23	Plan Code		Identifies product line and county
24	Paid	999.99	Capitation amount
25	Enrollment	1, -1 or 0	Enrollment (See note #25)
26	HCCA	99.9999	CMS Risk Score Part A
27	HCCB	99.9999	CMS Risk Score Part B
28	Band Begin	99	Age Band Begin

Capitation Data File Format Element Descriptions

29	Band End	999.9999	Age Band End
30	LOB		Line of Business
31	Pay Code	P1, P2, or NULL	Identifies when the payment is made (See note #31).
32	ACG Risk Score	999.99	
33	Normalized Risk Score	999.99	
34	COA Base Rate	999.99	

NOTES

Data Element

Element: 14

Note # 14: Member Number

The Member Number is the IEHP assigned number for each Member. An example of a Member Number is 19960900000100. Medi-Cal Members that became IEHP eligible in 9/96 have a Member Number that matches their original Medi-Cal #.

Element: 18

Note # 18: Member CIN

Client Index Number

A state assigned number to identify Medi-Cal Members. The first eight (8) characters are numeric and the last character is alpha.

Element: 19

Note # 19: Member SSN

A nine (9) digit number that is the primary and unique Member identifier.

For Medi-Cal Members, this field consists of one of the two (2) numbers:

SSN - Member SSN, or

PSEUDO - This number appears in this field if no SSN is available as provided by 834 File. First digit begins with the number "8" or "9" and ends with a letter.

CIN – Member Client Index Number if no SSN is available.

The following aid codes are covered aid codes by IEHP.

Capitation Data File Format Element Descriptions

Element: 16 & 21
Note # 16 & 21: Member Aid Code and Member Category of Aid

<u>MEDI-CAL</u>					<u>MEDICARE</u>		
<u>LTC</u>	<u>Child (Age Under 19) / Adult (Age 19 and over)</u>			<u>SPD</u>	<u>MCE</u>	<u>Dual Over 21</u>	<u>Dual Under 21</u>
<u>13</u>	<u>01</u>	<u>0A</u>	<u>4U</u>		<u>20</u>	<u>0L</u>	<u>7U</u>
<u>23</u>	<u>02</u>	<u>0E</u>	<u>4W</u>		<u>24</u>	<u>0M</u>	<u>L1</u>
<u>53</u>	<u>03</u>	<u>2C</u>	<u>5C</u>		<u>26</u>	<u>0N</u>	<u>M1</u>
<u>63</u>	<u>04</u>	<u>2P</u>	<u>5D</u>		<u>27</u>	<u>0P</u>	
	<u>06</u>	<u>2R</u>	<u>5K</u>		<u>2E</u>	<u>0R</u>	
	<u>07</u>	<u>2S</u>	<u>5L</u>		<u>2H</u>	<u>0T</u>	
	<u>08</u>	<u>2T</u>	<u>5V</u>	<u>P9</u>	<u>36</u>	<u>0U</u>	
	<u>30</u>	<u>2U</u>	<u>7A</u>			<u>0W</u>	
	<u>32</u>	<u>2V</u>	<u>7J</u>	<u>R1</u>		<u>10</u>	
	<u>33</u>	<u>3A</u>	<u>7S</u>		<u>60</u>	<u>14</u>	
	<u>34</u>	<u>3C</u>	<u>7W</u>		<u>64</u>	<u>16</u>	
	<u>35</u>	<u>3E</u>	<u>7X</u>		<u>66</u>	<u>17</u>	
	<u>37</u>	<u>3F</u>	<u>8E</u>	<u>T1</u>	<u>67</u>	<u>1E</u>	
	<u>38</u>	<u>3G</u>	<u>8P</u>	<u>T2</u>	<u>6A</u>	<u>1H</u>	
	<u>39</u>	<u>3H</u>	<u>8R</u>	<u>T3</u>	<u>6C</u>	<u>1X</u>	
	<u>40</u>	<u>3L</u>	<u>8U</u>	<u>T4</u>	<u>6E</u>	<u>1Y</u>	
	<u>42</u>	<u>3M</u>	<u>E2</u>	<u>T5</u>	<u>6G</u>		
	<u>43</u>	<u>3N</u>	<u>E5</u>		<u>6H</u>		
	<u>44</u>	<u>3P</u>	<u>E6</u>		<u>6J</u>		
	<u>45</u>	<u>3R</u>	<u>E7</u>		<u>6N</u>		
	<u>46</u>	<u>3U</u>	<u>H1</u>		<u>6P</u>		
	<u>47</u>	<u>3W</u>	<u>H2</u>		<u>6R</u>		
	<u>49</u>	<u>4A</u>	<u>H3</u>		<u>6W</u>		
	<u>54</u>	<u>4F</u>	<u>H4</u>		<u>6V</u>		
	<u>59</u>	<u>4G</u>	<u>H5</u>		<u>6X</u>		
	<u>72</u>	<u>4H</u>	<u>K1</u>		<u>6Y</u>		
	<u>76</u>	<u>4K</u>	<u>M3</u>		<u>L6</u>		
	<u>82</u>	<u>4L</u>	<u>M5</u>				
	<u>83</u>	<u>4M</u>	<u>M7</u>				
	<u>86</u>	<u>4N</u>	<u>M9</u>				

Capitation Data File Format Element Descriptions

	<u>87</u>	<u>4S</u> <u>4T</u>	<u>P5</u> <u>P7</u>							
MEDI-CAL							MEDICARE			
LTC	Child (Age Under 19)/ Adult (Age 19 and over)				SPD		MCE	Dual Over 21	Dual Under 21	
13	01	0A	4U	5C	20	0L	7U			
23	02	0E	4W	5D	24	0M	L1			
53	03	2C	5C	H1	26	0N	M1			
63	04	2P	5D	H2	27	0P	L6			
	06	2R	5K	H3	2E	0R				
	07	2S	5L	H4	2H	0T				
	08	2T	5V	P9	36	0U				
	30	2U	7A	H5	0N	0W				
	32	2V	7J	R1	0P	10				
	33	3A	7S	E6	60	14				
	34	3C	7W	E7	64	16				
	35	3E	7X	M5	66	17				
	37	3F	8E	T1	67	1E				
	38	3G	8P	T2	6A	1H				
	39	3H	8R	T3	6C	1X				
	40	3L	8U	T4	6E	1Y				
	42	3M	E2	T5	6G					
	43	3N	E5		6H					
	44	3P	E6		6J					
	45	3R	E7		6N					
	46	3U	H1		6P					
	47	3W	H2		6R					
	49	4A	H3		6W					
	54	4F	H4		6V					
	59	4G	H5		6X					
	72	4H	K1		6Y					
	76	4K	M3		L6					
	82	4L	M5							
	83	4M	M7							
	86	4N	M9							
	87	4S	P5							
		4T	P7							
		4U	E2							

Capitation Data File Format Element Descriptions

		4W	E5 M3 M7 P5 P7 P9 K1 86 0E 5L 8U R1 2C						
--	--	----	--	--	--	--	--	--	--

Capitation Data File Format Element Descriptions

Element: 20
Note # 20: Member Group

<u>MEDI-CAL</u> RIVERSIDE	<u>MEDI-CAL</u> SAN BERNARDINO	<u>Medicare</u> RIVERSIDE	<u>Medicare</u> SAN BERNARDINO
RVC-MED RVC-MMD RVC-CCI	SBC-MED SBC-MMD SBC-CCI	<u>IEHP DualChoice</u> <u>Cal-MediConnect</u>	<u>IEHP DualChoice</u> <u>Cal-MediConnect</u>

Element: 25
Note # 25: Enrollment

Each Member that capitation is paid for is counted as an enrollment of one (1). If we have to take back capitation that we previously paid for a Member (decapitation) the enrollment count for that Member is -1. The field “Enrollment” stands for either a positive enrollment (1) or a negative enrollment count (-1) or enrollment of 0.

Element: 31
Note # 31: Pay Code

Pay Code consists of three possible values P1, P2 or Null. P1 is for payments made on the 16th for the paid Capitation month. P2 and Nulls are for payments made at the end of the Capitation month.

P1=Mid-Month
 NULL, P2= End of Month

***IRREVOCABLE STANDBY LETTER OF CREDIT FOR
INCLUSION IN THE PROVIDER NETWORK OF THE
INLAND EMPIRE HEALTH PLAN***

BENEFICIARY: Inland Empire Health Plan
Governing Board
10801 Sixth Street, Suite 120
Rancho Cucamonga, CA 91730

ISSUE DATE: _____

APPLICANT: (IPA)

AMOUNT: _____ (USD)

DATE AND PLACE OF EXPIRY: _____

LETTER OF CREDIT NO.: _____
[Identification]

Re: Irrevocable Standby Letter of Credit delivered as security for Inclusion of _____ (IPA)
_____ in the Medical Provider Network of the Inland Empire Health Plan (“Agency”)

Members of the Board:

We hereby establish our Irrevocable Standby Letter of Credit in your favor available for payment by your draft(s) at sight drawn on _____ (Name and Place of Financial Institution)
_____ ; and accompanied by documents as specified below:

1. This original Irrevocable Standby Letter of Credit and any amendments thereto.
2. A signed and dated certification worded as follows:
3. “The Undersigned, the Chief Executive Officer, or Designee of the Chief Executive Officer, of the Inland Empire Health Plan, hereby certifies that there exists unpaid liabilities incurred by the IPA on behalf of an IEHP member, the terms of the capitation IPA agreement with IEHP are breached, and the time frame to cure said breach have been exhausted.”

___Special Conditions:

1. Partial Drawing allowed.
2. Multiple presentations allowed.
3. It is a condition of this Irrevocable Standby Letter of Credit that it shall be deemed automatically extended without amendment for additional ~~period of~~ one (1) year periods from the present or any future expiration date, not to exceed four (4) additional years after the initial term, unless, at least ninety (90) days prior to any expiration date _____ (Name of Financial Institution) shall notify the beneficiary, Inland Empire Health Plan,

Governing Board in writing by overnight courier service at the above address, that we elect not to extend this letter of credit for any such additional period. Upon such notice, ~~you~~ IEHP may draw, at any time prior to the expiration date, up to the full amount then available. The parties agree that upon the passage of a five (5) year term, a new Irrevocable Standby Letter of Credit shall be issued on behalf of the Inland Empire Health Plan on the same terms and subject to the same conditions herein.

We hereby guarantee ~~you~~ that all drafts drawn under and in compliance with the terms and conditions of this Irrevocable Standby Letter of Credit shall be duly honored if presented for payment at the office of _____ (Financial Institution) _____ on or before the expiration date of this Irrevocable Standby Letter of Credit.

Except so far as otherwise expressly stated, this Irrevocable Standby Letter of Credit is issued subject to the International Standby Practices 1998 (“ISP98”), ICC Publication no. 590. This Letter of Credit shall be deemed to be a contract made under the law of the State of California and shall, as to matters not governed by ISP98, be governed by and construed in accordance with the law of such State without regard to any conflicts of law provisions.

(Name of Financial Institution)

By: _____

By: _____

Attachment 19 - Remittance Advice - Medicare DualChoice Annual Visit

Happy Doctors Inc.
P.O. Box 1800
Rancho Cucamonga, CA 91729
123456789

Inland Empire Health Plan
Remittance Advice

Check Date: 04/19/2018
Check Amount: \$200.00
Check No: 1234567

Member #	Line Of Business	DOB	Patient Name				Provider Name														
Claim #	Line	Received Date	Service Date From	To	Proc	Mod	Qty	Amount Billed	Amount Allowed	Not Covered	Copay Amount	Deduct Amount	Withhold Amount	Net Paid	S T	Reason	Copay	Deduct	OthCarr	Adjust	
123456789456-00	MEDI-CAL	03/24/2017	Doe, Jane				Doctor Happy														
00000E1234567890	001	04/13/2018	03/30/2018	03/30/2018	99212		1	\$120.00	\$19.75	\$0.00	\$0.00	\$0.00	\$0.20	\$0.00	H	RECEIVED					
			Patient Account # 123456789456		Claim Totals			\$120.00	\$19.75	\$0.00	\$0.00	\$0.00	\$0.20	\$0.00							
			Member Totals					\$120.00	\$19.75	\$0.00	\$0.00	\$0.00	\$0.20	\$0.00							
			Provider Totals					\$120.00	\$19.75	\$0.00	\$0.00	\$0.00	\$0.20	\$0.00							
123456789456-00	MEDI-CAL	08/11/1977	Doe, Jill				Doctor Happy														
00000E1234567890	001	03/18/2018	12/18/2017	12/18/2017	88141	P	1	\$50.00	\$50.00	\$0.00	\$0.00	\$0.00	\$0.00	\$50.00	P	P4P					
			Patient Account # 123456789456		Claim Totals			\$50.00	\$50.00	\$0.00	\$0.00	\$0.00	\$0.00	\$50.00							
			Member Totals					\$50.00	\$50.00	\$0.00	\$0.00	\$0.00	\$0.00	\$50.00							
123456789456-00	MEDI-CAL	07/05/1988	Doe, Judy				Doctor Happy														
00000E1234567890	001	03/18/2018	01/29/2018	01/29/2018	88141	P	1	\$50.00	\$50.00	\$0.00	\$0.00	\$0.00	\$0.00	\$50.00	P	P4P					
			Patient Account # 123456789456		Claim Totals			\$50.00	\$50.00	\$0.00	\$0.00	\$0.00	\$0.00	\$50.00							
			Member Totals					\$50.00	\$50.00	\$0.00	\$0.00	\$0.00	\$0.00	\$50.00							
123456789456-00	MEDI-CAL	07/20/1978	Doe, Jackie				Doctor Happy														
00000E1234567890	001	03/18/2018	01/29/2018	01/29/2018	88141	P	1	\$50.00	\$50.00	\$0.00	\$0.00	\$0.00	\$0.00	\$50.00	P	P4P					
			Patient Account # 123456789456		Claim Totals			\$50.00	\$50.00	\$0.00	\$0.00	\$0.00	\$0.00	\$50.00							
			Member Totals					\$50.00	\$50.00	\$0.00	\$0.00	\$0.00	\$0.00	\$50.00							
			Provider Totals					\$150.00	\$150.00	\$0.00	\$0.00	\$0.00	\$0.00	\$150.00							
123456789456-00	MEDI-CAL	01/18/1966	Doe, Jen				Doctor Happy														
00000E1234567890	001	03/18/2018	01/30/2018	01/30/2018	88141	P	1	\$50.00	\$50.00	\$0.00	\$0.00	\$0.00	\$0.00	\$50.00	P	P4P					
			Patient Account # 123456789456		Claim Totals			\$50.00	\$50.00	\$0.00	\$0.00	\$0.00	\$0.00	\$50.00							
			Member Totals					\$50.00	\$50.00	\$0.00	\$0.00	\$0.00	\$0.00	\$50.00							
			Provider Totals					\$50.00	\$50.00	\$0.00	\$0.00	\$0.00	\$0.00	\$50.00							
			Vendor Account Totals					\$320.00	\$219.75	\$0.00	\$0.00	\$0.00	\$0.20	\$200.00							

***** Summary Page *****

Total Number Of Claims: 5
Total Number Of Claim Lines: 5
Total Payment Amount: \$200.00

***** Explanations Code Legend *****

P4P Pay For Performance Program

ST Code Legend: I - Informational, P - Payable, D - Denied, A - Adjustment, H - Claim Received & In Process

Please Note:

Medi-Cal and Healthy Kids

- Under the Knox-Keene Act, Health and Safety Code 1379 of the State of California and Title 22 of the California Code of Regulations, the patient to whom services were provided is not liable for any portion of the bill, except non-benefit items or non-covered services.
- Acknowledgement of claim receipt – Contracted Providers can confirm receipt of submitted claim(s) by logging into the Provider Portal at www.iehp.org. To obtain website instructions, please call IEHP Provider Relations Team at (909) 890-2054.
- In Compliance with AB1455, if you disagree with your payment, you may contact the IEHP Provider Relations Team at (909) 890-2054 or (866) 223-4347 Monday – Friday 8:00am to 5:00pm PST. You may also file a Provider Dispute within 365-days from the claim determination date. Disputes should be submitted to IEHP Claims Appeals Resolution Unit P.O. Box 4319, Rancho Cucamonga, CA 91729. Please visit www.iehp.org to obtain a Provider Dispute Resolution form online.
- In accordance with our agreement, negative balances will be offset against future claims to be paid to you.

Withhold Amount

By statute enacted in June 2011, (in response to the California budget crisis) effective July 1, 2011, Medi-Cal has reduced payments to specific Provider types by 10% with a corresponding reduction to Medi-Cal Managed Care Plans. Due to this legislative mandate, IEHP has reduced payments to impacted Providers referenced in the statute as follows:

- Services rendered from 10/01/13 to 12/31/14 are reduced by 10%.

IEHP Medicare DualChoice (HMO SNP), and IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan)

Withhold Amount – all Providers

- In accordance with Medicare mandated guidelines, your payment for dates of services on or after 04/01/13, may reflect a 2% sequestration reduction.

Contracted Providers

- Acknowledgement of claim receipt – Contracted Providers can confirm receipt of submitted claim(s) by logging into the Provider Portal at www.iehp.org. To obtain website instructions, please call IEHP Provider Relations Team at (909) 890-2054.
- In accordance with our agreement, negative balances will be offset against future claims to be paid to you.
- Appeals and Payment Dispute Requests – can be submitted within the timeframe indicated in your contract: IEHP DualChoice (HMO SNP) Claims Appeals and Resolution Unit P.O. Box 40, Rancho Cucamonga, CA 91729. Please visit www.iehp.org to obtain a Provider Dispute Resolution form online. For more information, please contact IEHP Provider Relations Team at (909) 890-2054 or (866) 223-4347.

Non Contracted Providers

Payment Appeals and Disputes for IEHP DualChoice (HMO SNP) and IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) Members should be submitted to IEHP at P.O. Box 40, Rancho Cucamonga, CA 91729

- Appeals - If you disagree with the outcome of a claim, you may submit an appeal attached with a Waiver of Liability and any supporting documentation within 60-days from the denial date. The waiver of liability form can be found on the CMS website – www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals reference Appendix 7.
- Payment Dispute Resolutions – If you disagree with the payment of a claim, you can submit your PDR with any supporting documentation within 120-days from the initial determination date. As a Non Contracted Provider you also have the option of sending your dispute to C2C Solutions Inc. For further information check their website regarding this process at PDRC@C2Cinc.com.
- Payment Disputes – If you disagree with the payment of a claim, you can submit your PDR with any supporting documentation within 120-days from the initial determination date.

Legal Notice

- Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to civil and criminal penalties in accordance with the State and Federal False Claims Acts.
- Please assist IEHP in preventing possible benefit abuse. Request another form of identification from the Member in addition to the IEHP card.

19. FINANCE AND REIMBURSEMENT

A. IPA Financial Viability

APPLIES TO:

- A. This policy applies to all IPAs participating in the IEHP DualChoice ~~line of business Cal MediConnect Plan (Medicare—Medicaid Plan) product line contracted with IEHP.~~

POLICY:

- A. IEHP complies with all regulatory requirements to protect its Members and Providers from the consequences of financial failure of an IEHP-contracted IPA.
- B. IEHP monitors the financial viability of all contracted IPAs and has established funding requirements to ensure all contracted IPAs are financially sound and can handle the risks associated with capitation.
- C. IEHP requires all contracted IPAs to meet IEHP's and California Department of Managed Health Care's (DMHC) financial viability standards/requirements for Risk ~~B~~bearing Organizations (RBOs) ~~as stated within the California Code of Regulations Title 28 §1300.75.4.2~~ prior to Member assignment to the IPA's Primary Care Providers (PCPs) and on an ongoing basis.¹

PROCEDURES:

- A. Prior to entering into a contractual agreement with IEHP and annually thereafter, IPAs must submit their most current audited financial statements, and their most recent monthly and year-to-date financial statements comprising Balance Sheets, Income Statements, Cash Flow Statements and supporting worksheets for incurred, but not reported (IBNR) or IBNR certification by an independent, certified actuary mutually acceptable to IEHP. Additionally, the IPA must submit their required periodic financial and organizational information disclosures ~~as stated in section 1300.75.4.2 of Title 28 California Code of Regulations~~ as an RBO within five (5) business days after the due date.² The financial statements must demonstrate that the IPA is financially viable and is able to meet IEHP's and DMHC's financial viability standards/requirements as referenced above. IEHP does not contract with IPAs that do not meet these standards.
- B. On an ongoing basis, all contracted IPAs are required to submit to IEHP a copy of their financial statements comprising Balance Sheets, Income Statements, Cash Flow Statements and supporting worksheets for IBNR on a quarterly basis within forty-five (45) days of the end of each calendar quarter. Additionally, the IPA must submit their required periodic financial and organizational informational disclosures as stated in section 1300.75.4.2 of Title 28 California Code of Regulations as an RBO within five (5) business days after the due date.³

¹ Title 28 California Code of Regulations (CCR) §1300.75.4.2

² Ibid.

³ ~~28 CCR §1300.75.4.2~~ Ibid.

19. FINANCE AND REIMBURSEMENT

A. IPA Financial Viability

When requested, IPAs shall also provide written explanation within two (2) weeks substantiating any of the following (but not limited to):

1. Cash & Cash Equivalents including Restricted Assets
 2. All Receivables – Current and Long Term
 3. All Liabilities – Current and Long Term, including IBNR
 4. Any Due To/From Shareholders/Partnership
 5. Any Intercompany or Related Transaction
 6. Revenues
 7. Medical Expenditures
 8. General and Administrative Expenditures
- C. On an annual basis, all contracted IPAs are required to submit annual audited financial statements, including IBNR certification to IEHP for compliance review no later than ~~one one hundred~~ one hundred-fifty (150) days after the end of the IPA's fiscal year. Additionally, the IPA must submit their required periodic financial and organizational informational disclosures ~~as stated in section 1300.75.4.2 of Title 28 California Code of Regulations~~ as an RBO within five (5) business days after the due date.⁴
- D. Financial statements must clearly display the financial condition of the entity that holds the contract with IEHP. Submission of related party, affiliate, consolidated or parent company financials are not acceptable. Consolidating financial statements are only acceptable if the financial condition of the IEHP contracted entity is clearly documented and identified. Consolidating financial statements must clearly identify any inter-company transactions between related parties, affiliates, or parent company.
- E. IEHP will review the financial statements submitted by the IPAs to ensure the following IEHP financial viability standards/requirements are always met:
1. Maintained a positive Tangible Net Equity (TNE) ~~as defined in section 1300.76 of the Title 28 California Code of Regulations.~~⁵
 2. Maintained a positive working capital calculated in a manner consistent with Generally Accepted Accounting Principles (GAAP).
 3. The Current Ratio (the ratio of current assets to current liabilities) always exceeds 100%.
 4. Quick ratio is always greater than 1.0.
 5. Debt Coverage Multiple is always greater than 1.2.
 6. Cash to Claims Ratio is always 0.75 or greater.

⁴ 28 CCR §1300.75.4.2

⁵ 28 CCR §1300.76

19. FINANCE AND REIMBURSEMENT

A. IPA Financial Viability

7. Medical Expense Ratio is always less than ~~0.89~~;0.89.
 8. The plan must be notified if claims payable days outstanding is more than four (4) months
 9. The plan must be notified if accounts receivable days outstanding is more than sixty (60) ~~days~~;days.
 10. Total Assets, (Net of Intangibles and/or Due from Officers, Directors, and Affiliates) as reported on the financial statements, shall fully fund Incurred But Not Reported (IBNR) ~~claims~~;claims.
 11. IBNR calculation worksheets that support the amounts represented on the financial statements accompany all submissions. IPAs must also provide the following:
 - a. The methodology used to calculate IBNR
 - b. The data and work papers to substantiate IBNR
 - c. Independent review and certification, if necessary, by:
 - 1) IEHP
 - 2) -IPA's Actuary
- F. If for any reason the IPA's Medical Expense ratio is above 0.89, as set forth in section E.7 of this policy, then the following will be required of the IPA:
1. Medical Expense Ratio greater than 0.89, up to 0.95 - IPA must submit monthly claim lag tables.
 2. Medical Expense Ratio greater than 0.95 - IPA must submit the following documentation:
 - a. -Requirement noted above (in section F.1)
 - b. As well as a monthly income statement with detailed explanations of the nature of the deficiency, the reasons for the deficiency, and any actions taken to correct the deficiency within fifteen (15) days of month-end close; and
 - c. Increase the Letter of Credit (LOC) on file by the deficiency amount of the TNE.
- G. IEHP reserves the right to request additional detailed work papers supporting account balances represented on the IPA's or Management Service Organization's (MSO) financial statements.
- H. IEHP reserves the right to ask for more frequent financial reports and information upon written notice to the IPA and making appropriate inquiries of the IPA's key financial personnel during any review.
- I. IEHP reserves the right to approve or deny use of a particular MSO by the IPA.
- J. All contracted IPAs shall also have the ability to secure an Irrevocable Standby LOC (See Attachment, "Irrevocable Letter of Credit" in Section 19), with IEHP as the beneficiary, prior

19. FINANCE AND REIMBURSEMENT

A. IPA Financial Viability

to receiving Member enrollment, and quarterly thereafter.⁶ This requirement will be waived for IPAs having a Limited Knox-Keene license.

- K. The LOC secured amounts generally are linked to the IPA's combined ownership of IEHP enrollment as follows:

IPA's enrollment	Deposit Requirement
Up to - 10,000	\$100,000.00
10,001 - 20,000	\$200,000.00
20,001 -30,000	\$300,000.00
30,001 - 40,000	\$400,000.00
40,001 - 50,000	\$500,000.00
50,001 – 60,000	\$600,000.00
60,001 – 70,000	\$700,000.00
70,001 – 80,000	\$800,000.00
80,001 – 90,000	\$900,000.00
90,001 plus	\$1,000,000.00

- L. Enrollment levels will be reviewed at the end of the reporting quarter, and LOC deposit amounts adjusted, as applicable, within thirty (30) days after the end of the reporting quarter.
- M. In addition to securing an Irrevocable Standby LOC with IEHP as the beneficiary, IPAs are also required to establish a restricted cash reserve in the amount of 25% of the average monthly capitation revenue for the reporting quarter. This requirement will be waived for IPAs having a Limited Knox-Keene license.
- N. In order to satisfy the restricted cash reserve requirement, IPAs have the following options:
1. Secure an Irrevocable Standby LOC designating IEHP as the beneficiary.
 2. Elect to have the monthly IPA capitation revenue adjusted by IEHP.
- O. IEHP reserves the right to increase the LOC amount for a IPA failing to meet TNE requirements by the amount the IPA is deficient, which may be in addition to the deposit required based on enrollment.
- P. IEHP reserves the right to increase the LOC amount for an IPA based on either the enrollment level or IBNR, whichever one is higher.
- Q. Letters of Credit (~~LOC~~) backed by an agreed upon future loan from a financial institution will require the IPA to submit a complete list of all LOCs on record with other Health Plan

⁶ International Standby Practices 1998, ICC Publication No. 590

19. FINANCE AND REIMBURSEMENT

A. IPA Financial Viability

organizations. These LOCs should also be clearly listed and described in the notes to the financial statements.

- R. Letters of Credit backed by funds deposited within a secured location such as a financial institution must remain in place for the entire contract year and for one hundred eighty (180) days after the contract expiration/termination.
- S. If the IPA fails to meet any of the above referenced standards, IEHP may take the following actions:
1. Freeze the IPA to new membership;
 2. Place the IPA in a contractual cure for breach of contract;
 3. Seize any capitation and/or monies owed and place the IPA under Financial Supervision until breach is cured; ~~and~~
 - a. Financial Supervision to include:
 - 1) Withholding of monthly capitation
 - 2) Managing and releasing withheld capitation to the IPA to fund:
 - Administrative Expenses
 - PCP Capitation Payments
 - Claims Payments - limited specifically to months/DOS withheld capitation was intended. ~~for payment~~
 - 3) Reviewing financial statements, bank statements and/or other records to ensure payments are made. ~~payment~~
 4. Immediately terminate the IEHP/ IPA Agreement for cause.
- T. In the event an IPA fails to perform a financial covenant of its IEHP contract, IEHP may exercise its ability to draw down on the deposit or line of credit for its full amount.
- U. The above procedures, including LOC Requirements, may be adjusted by other factors that provide similar financial security as determined by the IEHP Chief Executive Officer or designee of the IEHP Chief Executive Officer.
- V. Upon request by IPA(s), at its sole discretion, IEHP may change/waive any/or part of the IPA Financial Viability Requirements as it deems necessary either globally or specific to an IPA.

19. FINANCE AND REIMBURSEMENT

A. IPA Financial Viability

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	January 1, 2007
Chief Title: Chief Operating <u>Financial</u> Officer	Revision Date:	January 1, 202 <u>3</u>

19. FINANCE AND REIMBURSEMENT

C. Pay For Performance

1. Medicare DualChoice Annual Visit

APPLIES TO:

- A. This policy applies to all IEHP Direct DualChoice ~~Cal MediConnect Plan (Medicare—Medicaid Plan)~~ Members.

POLICY:

- A. The IEHP's **Pay for Performance (P4P) Medicare DualChoice Annual Visit Program** ~~was~~ is designed to increase the provision of preventive health services to IEHP Members as well as improve HEDIS® results to ensure that all IEHP DualChoice Members receive timely annual visits with an emphasis on review and management of chronic illness.
- B. IEHP Direct PCPs are automatically enrolled in ~~this~~ P4P programs upon completion of IEHP's credentialing process.

PURPOSE:

- A. To improve the quality of care to IEHP Members and increase compliance with California Department of Health Care Services (DHCS), Centers for Medicare & Medicaid Services (CMS) and HEDIS® requirements.
- B. To ensure proper reimbursement to IEHP Direct PCPs participating in Medicare DualChoice Annual Visit P4P Program.

PROCEDURES:

- A. **Medicare DualChoice Annual Visit P4P**
1. PCPs who are credentialed with IEHP Direct and participating in the IEHP DualChoice Program are eligible for ~~the~~ Medicare DualChoice Annual Visit component.
 2. Only PCPs who are assigned IEHP Direct DualChoice Members are eligible for the Medicare DualChoice Annual Visits P4P component.
- B. The PCP can only receive reimbursement for an active Member who is assigned to them on the date services are provided, unless otherwise specifically noted.
1. Participating IEHP Direct PCPs must record significant chronic diagnoses and document history and physical findings related to these diagnoses in the medial record.
 2. The Medicare_DualChoice Annual Visit form is available on the Member Eligibility Webpage. A copy of this form should be printed prior to the Member's visit.
 3. Participating IEHP Direct PCPs must review the "Diagnosis Review" sections of the Medicare DualChoice Annual Visit form. The conditions need to be confirmed, identified with the appropriate ICD code(s) and noted with its respective assessment/plan.

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1. Medicare DualChoice Annual Visit

4. Participating IEHP Direct PCPs are paid \$200 per each annual visit completed for an eligible IEHP Direct DualChoice Member. The incentive is paid in addition to the PCP's fee for service visit reimbursement or their capitated PCP agreement.
5. Only one (1) exam per year qualifies for this incentive, regardless of if the IEHP DualChoice Member has had several PCPs and multiple exams.
6. Medicare DualChoice Annual Visits must only be submitted securely -via www.iehp.org using the appropriate form.
 - a. Member's significant conditions/diagnoses must be assessed in total at the annual visit. Accurate clinical documentation and ICD coding reflecting the Member's condition/diagnoses must be entered on the form, including appropriate assessments and plans.
 - b. Completed annual visit forms must be submitted online to IEHP within one hundred eighty (180) calendar days from the date of service and must meet IEHP's submission standards to qualify for the incentive.
 - c. Failure to submit completed forms within the required timeframes will result in denial of reimbursement. IEHP will not accept or reimburse initial paper submissions made via mail or fax except corrective resubmission only.
7. Reimbursements are made within thirty (30) working days of receipt of a complete Medicare DualChoice Annual Visit form submitted online.

B. P4P Reports

1. Providers can print summary remittance advice reports with each payment distribution (See Attachments, "Remittance Advice – Medicare DualChoice Annual Visit" in Section 19). To access Remittance Advice (RAs) online, log on to the secure site login at www.iehp.org.

C. P4P Audit Process

1. IEHP conducts on-going audits of P4P Providers for compliance with P4P requirements, including submission accuracy, completeness of forms and supporting documentation in the Member's medical record for submitted reimbursement.
2. Providers are notified in writing approximately two (2) weeks prior to the targeted audit date. ~~IEHP follows up with a phone call to schedule the audit.~~
3. IEHP provides the names of the Members' charts to pull two (2) days prior to the scheduled audit.
4. IEHP provides the Provider with written notice of the findings within thirty (30) days of the audit date. Providers have thirty (30) days to respond to the findings.

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1. Medicare DualChoice Annual Visit

~~5. Providers not responding to Corrective Action Plan (CAP) requests are subject to removal from participation in P4P.~~

~~6.5.~~ Depending on the nature and severity of the findings and the Provider's response (including non-responses), IEHP may take, but are not limited to, the following actions against the Provider ~~up to and including, but not limited to:~~

- a. Recoupment of all or a portion of the incentives paid under P4P for services deemed inappropriately performed and reimbursed;
- b. Removal from participation in P4P;
- c. Referral to the Peer Review Subcommittee and/or IEHP's Fraud Prevention Committee; and/or
- d. Removal from participation in the IEHP network.

~~7.6.~~ Providers removed from P4P for non-response to CAP requests, or because of the severity of the findings, may appeal the removal decision by submitting a written appeal to IEHP.

~~8.7.~~ Providers removed from P4P may not re-apply for participation for six (6) months. Providers removed from P4P more than twice are prohibited from future participation.

D. P4P Appeals/Inquiries/Corrections

1. Providers with any appeals related to previously denied P4P reimbursements may contact the IEHP Provider Relations Team at (909) 890-2054 or (886) 223-4347 Monday – Friday 8:00 am to 5:00 pm PST. Provider may also file an appeal within one hundred and twenty (120) days from the claim determination date.
2. The rendering Provider must attach a cover letter clearly indicating the reason for the appeal or may complete the Provider Dispute Resolution request form that can be downloaded online at <https://iehp.org/en/providers/provider-resources?target=forms#FormsClaims>.
3. The Medicare DualChoice Annual Visits disputes or corrections should be submitted to:

Inland Empire Health Plan
Attention: Quality Informatics
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800

4. Required information must include the specific services the Provider is appealing or inquiring and the reason the appeal should be considered in the Comments Section of the Appeal form. Incomplete information may cause a delay in the resolution of the appeal or inquiry.

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C. Pay For Performance

1. Medicare DualChoice Annual Visit

E. Future Changes to P4P Program

1. IEHP reserves the right to change any component of these Programs at any time.
2. All decisions regarding the rules, requirements and compensation under the Programs are at the sole discretion of IEHP.

19. FINANCE AND REIMBURSEMENT

C. Pay For Performance

1. Medicare DualChoice Annual Visit

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	January 1, 2007
Chief Title: Chief Operating Officer	Revision Date:	January 1, 2023

19. FINANCE AND REIMBURSEMENT

D. IPA Financial Supervision

APPLIES TO:

A. This policy applies ~~for to~~ all IPAs contracted with IEHP.

POLICY:

- A. IEHP complies with all regulatory requirements to protect its Members and Providers from the consequences of financial failure of an IEHP-contracted IPA.
- B. IEHP requires all contracted IPAs to meet IEHP's and California Department of Managed Health Care's (DMHC) financial viability standards/requirements for Risk Bearing Organizations (RBOs) ~~under section 1300.75.4.2 of Title 28 California Code of Regulations~~ prior to assignment of Members to the IPA's Primary Care Providers (PCPs) and on an ongoing basis.¹
- C. IEHP monitors the financial viability of all contracted IPAs and has established funding requirements to ensure all contracted IPAs are financially sound and can handle the risks associated with capitation.
- D. IEHP shall place IPAs under the financial supervision program in the event an IPA is in breach of its contract with IEHP due to non-compliance with IEHP's financial viability standards and/or with the above-mentioned California regulation requirements.

PROCEDURES:

- A. ~~For~~ IPAs failing to meet IEHP's financial viability standards ~~and/or with section 1300.75.4.2 of Title 28 California Code of Regulations~~ requirements, shall be required to complete a Corrective Action Plan (CAP).² The CAP shall include a timeline for when the IPA shall come into compliance with the financial viability requirements. IEHP shall place the IPA under Financial Supervision until breach is cured.
- B. IPAs under Financial Supervision due to contractual breach may be subject to any or all of following actions at IEHP's discretion:
 - 1. ~~Freeze-Freezing to of~~ new membership.
 - 2. Withholding of monthly capitation revenue and other monies owed to the IPA.
 - 3. Managing and releasing withheld capitation and other monies owed to the IPA to fund:
 - a. Administrative Expenses funded monthly as specified in the IPA/Management Services Organization (MSO) contract.
 - b. PCP Capitation Payments for IEHP enrollees funded monthly for the current capitation period based on submission of a check run.

¹ Title 28 California Code of Regulations (CCR) §1300.75.4.2

² Ibid.

19. FINANCE AND REIMBURSEMENT

D. IPA Financial Supervision

- c. Fee-For-Service (FFS) claims payments for professional services rendered to IEHP enrollees funded monthly or at other intervals to coincide with IPA check runs limited specifically to months/date-of-service (DOS) withheld capitation was intended for payment.
- d. Any other legitimate business expense subject to approval by IEHP.
- 4. Withdrawal of the funds available in the Standby Letter of Credit (LOC)
- 5. Immediate termination as stated in the IPA contract.
- C. Any exceptions to the above including the limitation for FFS payments to fund existing claims ~~run-out~~run out (IBNR) must be approved by IEHP.
- D. Any remaining funds resulting from the implementation of the Financial Supervision may be netted against any claims expenses paid by IEHP for that IPA.
- E. IEHP shall review financial and other statements, including bank statements and/or other records to ensure payments are made and checks have been cleared.

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19. FINANCE AND REIMBURSEMENT

D. IPA Financial Supervision

Chief Title: Chief Operating Officer	Revision Date:	January 1, 202 2 <u>3</u>
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