19. FINANCE AND REIMBURSEMENT

A. IPA Financial Viability

APPLIES TO:

A. This policy applies to all Medi-Cal 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 monitors the financial viability of all contracted IPAs and has established financial standards and reporting 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 Bearing Organizations (RBOs) prior to Member assignment to the IPA's Primary Care Providers (PCPs) and on an ongoing basis.[1]

D. IEHP performs financial audits on IPAs annually or as necessary. Financial audits are focused on determining the IPA's financial viability and the ability to manage risks associated with capitation and not presenting undue risk to IEHP or its providers or members.

E. Audits may include on-site review and evaluation of written policies and procedures, financial statements, contracts, management involvement and oversight, and interviews with key personnel.

F. Audited IPAs are required to cure any deficiencies to bring them into contractual and regulatory compliance.

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 of 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 by the 15th of each month for the previous month's activity. Additionally, the IPA must submit their required periodic financial and organizational informational disclosures as an RBO within five (5) business days after the due date.[2]

   1. 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. When

[1] Title 28 California Code of Regulations (CCR) §1300.75.4.2
[2] Ibid.

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

i. Cash & Cash Equivalents including Restricted Assets

ii. All Receivables – Current and Long Term

iii. All Liabilities – Current and Long Term, including IBNR

iv. Any Due To/From Shareholders/Partnership

v. Any Intercompany or Related Transaction

vi. Revenues

vii. Medical Expenditures

a. General and Administrative Expenditures

B. Monthly, all contracted IPAs are required to submit the IEHP Financial Template by the 15th of each month for the previous month's activity. The template comprises information from the IPA's Balance Sheet, Income Statement and Cash Flows and is not meant to replace the IPA's submission of their financial statements. IEHP reserves the right to make changes to the IEHP Financial Template as it deems necessary.

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 150 days after the end of the IPAs fiscal year. Additionally, the IPA must submit their required periodic financial and organizational informational disclosures as an RBO within five (5) business days after the due date.[3]

D. Financial information submitted by the IPAs 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 is 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 transaction between related parties, affiliates or parent company.

E. IEHP will review the financial information submitted by the IPAs to ensure the following IEHP financial viability standards/requirements are always met:

1. Maintained a positive Tangible Net Equity (TNE).[4]

a. Maintained a positive working capital calculated in a manner consistent with Generally Accepted Accounting Principles (GAAP).

b. The Current Ratio (the ratio of current assets to current liabilities) always exceeds 100%.

c. Quick ratio is always greater than 1.0.

[3] 28 CCR §1300.75.4.2
[4] 28 CCR §1300.76

d. Debt Coverage Multiple is always greater than 1.2.

e. Cash to Claims Ratio is always 0.75 or greater.

f. Medical Loss Ratio (MLR) is always between 0.85 and 0.95 to ensure adequate spend on care and maintain solvency.

g. IEHP must be notified if claims payable days outstanding is more than four (4) months.

h. IEHP must be notified if accounts receivable days outstanding is more than 60 days.

i. 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.

j. IBNR calculation worksheets that support the amounts represented on the financial statements accompany all submissions. IPAs must also provide the following:

i The methodology used to calculate IBNR

ii The data and work papers to substantiate IBNR

iii Independent review and certification, if necessary, by:

(1) IEHP

(2) IPA's Actuary

G. If the IPA's MLR is less than 0.85 or greater than 0.95, as set forth in section E.7 of this policy, then the IPA must submit the following:

1. Monthly claim lag tables.
2. Monthly financial statements with detailed explanations of the nature of the deficiency, the reasons for the deficiency, and any actions taken to correct the deficiency within 15 days of month-end close; and
3. If deemed necessary, increase the Letter of Credit (LOC) on file by the deficiency amount of the TNE.

H. 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.

I. 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.

J. IEHP reserves the right to approve or deny use of a particular MSO by the IPA.

K. IEHP notifies contracted IPAs in writing at least six (6) weeks in advance of the scheduled annual audit. The notice is explicit in the timeframe being audited, the request for reports, documents, access to key personnel, and if appropriate, dates and requirements for on-site

visits. For focused audits, IEHP reserves the right to give a minimum of three (3) working days prior notice.

L. IEHP reserves the right to perform audits more frequently than once annually if circumstances arise that in the judgment of IEHP management requires closer scrutiny including but not limited to the following circumstances:

1. Failure of any financial viability standards/requirements.
2. Failure to submit accurate and completed reports to IEHP within specified timeframes.
3. Material misstatements identified in the IPA's financials.
4. Notice of non-compliance from regulatory agencies.

M. Within 30 days of the last day of the audit IEHP sends an audit report to the IPAs documenting the findings, and if necessary, recommended corrective actions. IPAs with recommended corrective actions will be required to complete a Corrective Action Plan (CAP). See Policy 19B, "Financial Supervision."

N. All contracted IPAs must also have the ability to secure an Irrevocable Standby LOC (See "Irrevocable Letter of Credit" found on the IEHP website[5]), with IEHP as the beneficiary, prior to receiving Member enrollment, and quarterly thereafter.[6] This requirement will be waived for IPAs having a Limited Knox-Keene license.

O. 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**

[5] https://www.providerservices.iehp.org/en/resources/provider-resources/forms
[6] International Standby Practices 1998, ICC Publication No. 590

90,001 plus	**$1,000,000.00**

P. Enrollment levels will be reviewed at the end of the reporting quarter, and LOC deposit amounts adjusted, as applicable, within 30 days after the end of the reporting quarter.

Q. 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.

R. 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.

S. IEHP reserves the right to increase the LOC amount for an 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.

T. IEHP reserves the right to increase the LOC amount for an IPA based on either the enrollment level or IBNR, whichever one is higher.

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

V. 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 180 days after the contract expiration/termination.

W. 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.
    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.

3) Reviewing financial statements, bank statements and/or other records to ensure payments are made.

4. Immediately terminate the IEHP/ IPA Agreement for cause.

X. 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.

Y. 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 (CEO) or designee of the IEHP Chief Executive Officer (CEO).

Z. 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.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☒ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

19. FINANCE AND REIMBURSEMENT

A. Financial Viability

1. Network Providers, Subcontractors and Downstream Contractors

APPLIES TO:

A. This policy applies to all Network Providers, Subcontractors and Downstream Contractors.

POLICY:

A. IEHP complies with all regulatory requirements to protect its Members and Providers from the consequences of financial failure of a Network Provider, Subcontractor or Downstream Contractors.

B. IEHP monitors the financial viability of all Network Providers and Subcontractors and has established financial requirements to ensure all are financially viable.

C. IEHP monitors the Subcontractors' oversight of the financial viability of all Downstream Contractors including the financial requirements to ensure all are financially viable.

D. IEHP requires all Network Providers, Subcontractors and Downstream Contractors to meet IEHP's and California Department of Managed Health Care's (DMHC) financial viability standards/requirements for Risk Bearing Organizations (RBOs).[1]

PROCEDURES:

A. Prior to entering into a contractual agreement with IEHP, Providers and Subcontractors must submit their most current audited financial statements and their most recent monthly and year-to-date financial statements comprising Balance Sheets, Income Statements, and Cash Flow Statements. Additionally, the Provider must submit their periodic financial and organizational informational disclosures as stated in section 1300.75.4.2 of Title 28 California Code of Regulations of the Knox Keene Act as an RBO within five (5) business days after the due date. The financial statements must demonstrate that the Provider 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 Providers that do not meet these standards.

B. Prior to entering into a contractual agreement with IEHP and annually thereafter, Network Providers, Subcontractors, and Downstream Contractors will complete the IEHP Self-Reporting Financial Viability Questionnaire (See "Self-Reporting Financial Viability Questionnaire" found on the IEHP website) [2] to ensure the following IEHP financial viability standards/requirements are met at all times:

Liquidity and Leverage

1. Days Cash on Hand = (unrestricted cash + cash equivalents) / average daily cost of operations (= annual operating cost / 365); minimum of 90 days.

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

[2] https://www.providerservices.iehp.org/en/resources/provider-resources/forms

2. Cash Flow Coverage Ratio = operating cash flow / total debt (or debt expense); minimum of 1.5.
3. Current Ratio = current assets / current liabilities, minimum of 1.0.
4. Tangible Net Equity = (Total Assets – Intangibles – Unsecured Assets) – Total Liabilities, must be positive.

Activity

1. Net Collections Ratio = adjusted (for contract adjustments) received / billed; minimum 95%.

Profitability

1. Net Margin for the reporting year and prior two years = net income / revenue; to track trend.

C. IEHP reserves the right to require Network Providers, Subcontractors and Downstream Contractors to submit annual audited financial statements to IEHP (Downstream Contractors must submit to the Subcontractors) for compliance review. When requested, Providers, Subcontractors and Downstream Contractors 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

D. Financial statements must clearly display the financial condition of the entity that holds the contract with IEHP/Subcontractor. Submission of related party, affiliate, consolidated or parent company financials are not acceptable. Consolidating financial statements is only acceptable if the financial condition of the contracted entity is clearly documented and identified. Consolidating financial statements must clearly identify any inter-company transaction between related parties, affiliates, or parent company.

E. IEHP reserves the right to request additional detailed work papers supporting account balances represented on the financial statements.

F. IEHP reserves the right to ask for more frequent financial reports and information upon written notice to the Providers, Subcontractors and Downstream Contractors and make appropriate inquiries of their key financial personnel during any review. If the Provider, Subcontractor or Downstream Contractor fails to meet any of the above referenced standards, IEHP may take the

following actions:

1. Place the Provider in a contractual cure for breach of contract
2. Immediately terminate the IEHP/Provider Agreement for cause.

G. The above procedures 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.

H. Upon request by Provider(s), at its sole discretion, IEHP may change/waive any/or part of the Provider Financial Viability Requirements as it deems necessary.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☒ CMS
	☒ DMHC	☒ NCQA
Original Effective Date:	January 1, 2024	
Revision Effective Date:		

19. FINANCE AND REIMBURSEMENT

B. IPA Financial Supervision

APPLIES TO:

A. This policy applies to all Medi-Cal 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 Delegate's.

B. IEHP requires all contracted Delegate's to meet IEHP's and California Department of Managed Health Care's (DMHC) financial viability standards/requirements for Risk Bearing Organizations (RBOs) prior to assignment of Members to the Delegate's Primary Care Providers (PCPs) and on an ongoing basis.[1]

C. IEHP monitors the financial viability of all contracted Delegate's and has established funding requirements to ensure all contracted Delegate's are financially sound and can handle the risks associated with capitation.

D. IEHP shall place Delegate's under the financial supervision program in the event a Delegate 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. Delegate's failing to meet IEHP's financial viability requirements, shall be required to complete a Corrective Action Plan (CAP).[2] The CAP shall include a timeline for when the Delegate shall come into compliance with the financial viability requirements. IEHP shall place the Delegate under Financial Supervision until breach is cured.

B. Delegate's under Financial Supervision due to contractual breach may be subject to any or all of following actions at IEHP's discretion:

   1. Freezing to new membership.
   2. Withholding of monthly capitation revenue and other monies owed to the Delegate.
   3. Managing and releasing withheld capitation and other monies owed to the Delegate to fund:
      a. Administrative Expenses funded monthly as specified in the Delegate/Management Service Organization (MSO) contract.

[1] Title 28 California Code of Regulations (CCR) §1300.75.4.2
[2] Ibid.

b. PCP Capitation Payments for IEHP enrollees funded monthly for the current capitation period based on submission of a check run.

c. Fee-For-Service (FFS) claims payments for professional services rendered to IEHP enrollees funded monthly or at other intervals to coincide with Delegate 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 Delegate contract

C. Any exceptions to the above including the limitation for FFS payments to fund existing claims 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 Delegate.

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		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☒ DMHC	☐ NCQA
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Revision Effective Date:	January 1, 2024	

19. FINANCE AND REIMBURSEMENT

C. Pay For Performance

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal credentialed OB/GYN Providers.

POLICY:

A. The OB/GYN Quality Pay-for-Performance (P4P) program provides an opportunity for IEHP's OB/GYN Providers to earn a performance-based financial incentives for improving the quality of maternity care for IEHP's pregnant and postpartum Members. Incentive payments are administered for select prenatal and postpartum services performed by eligible Providers to IEHP Members who meet the program criteria. See the current Pay for Performance (P4P) Program Technical Guide at https://ww3.iehp.org/en/providers/p4p-prop56-gemt for full program details.

B. There are eight (8) maternity care measures, including postpartum care measures, for which OB/GYN Providers are eligible to receive a financial incentive. IEHP identified these as plan-wide areas of opportunity to improve the care and outcomes of Members receiving pregnancy-related health care services.

1. Initial Prenatal Visit
2. Perinatal Chlamydia Screening
3. Perinatal Depression Screening
4. Postpartum Blood Pressure Screening
5. Postpartum Diabetes Screening
6. Early Postpartum Visit
7. Later Postpartum Visit
8. Tdap Vaccine

Technical specifications and details for each P4P measure are included in the Appendix of the current Pay for Performance (P4P) Program Technical Guide that is available on the IEHP website at https://ww3.iehp.org/en/providers/pay-for-performance?target=ob-p4p-program.

PURPOSE:

A. To improve the quality of care to IEHP Members and increase compliance with DHCS, CMS and HEDIS® requirements.

B. To ensure proper reimbursement to PCPs participating in OB/GYNs participating in the OB/GYN Quality P4P program.

PROCEDURES:

A. OB/GYN Quality Pay-for-Performance (P4P) Program

1. Any IEHP Provider credentialed to provide obstetrical and gynecological services is eligible to participate in the OB/GYN Quality P4P program and earn financial incentives.
2. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are not eligible to participate in the IEHP OB/GYN P4P Program.
3. Providers who are assigned IEHP Medi-Cal and IEHP DualChoice Members who are pregnant, are eligible for the OB/GYN Quality P4P Program.
4. Providers must complete and submit codes with required modifiers for P4P services by means of electronic claim submission (CMS-1500) to IEHP via their clearinghouse or by submitting a paper CMS-1500 form to IEHP's Claims Department:

   Inland Empire Health Plan
   ATTN: Claims Department
   P.O. Box 4349
   Rancho Cucamonga, CA 91729-4349

   CMS-1500 forms must be submitted within two months of the date of service (DOS) and meet coding requirements as noted in the Appendix of the 2020 P4P OB/GYN Program Guide to be eligible for an incentive payment. The Pay for Performance (P4P) Program Guide can be found at https://ww3.iehp.org/en/providers/pay-for-performance?target=ob-p4p-program. To avoid possible bundling of codes, P4P incentive claims should be billed separately from claims for routine services.
5. IEHP will issue incentive payments to Providers through their regular claims remittance. OB/GYN P4P claims are processed through the same claims process as traditional claims.

B. P4P Reports

1. Providers can print remittance advice reports with each payment. To access Remittance Advices (RAs) online, log on to the secure Provider portal 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.
3. IEHP provides the names of the Members, whose records must be pulled two (2) business days prior to the scheduled audit.

4. IEHP provides the Providers with written notice of the findings within thirty (30) business days of the audit date. Practitioners have thirty (30) business days to respond to the findings.
5. Providers that do not respond to Corrective Action Plan (CAP) requests are subject to removal from participation in P4P.
6. Depending on the nature and severity of the findings and the Provider's response (including non-responses), IEHP may take action against the Provider, including but are 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. 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 as stated in Policy 16C2, "Dispute and Appeal Resolution Process for Providers - Health Plan."
8. 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/Correction

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. Providers may also file an Appeal within one hundred and twenty (120) days from the claim determination date.
2. P4P Providers of service must attach a cover letter clearly indicating the reason for the appeal or complete the Provider Dispute Resolution request form that can be downloaded online at www.iehp.org.
3. For OB/GYN P4P, Disputes should be submitted to:

   IEHP Claims Appeal Resolution Unit
   P.O. Box 4319
   Rancho Cucamonga, CA 91729-4319

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 your Appeals or Inquiry.

E. Future Changes to P4P Program

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

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2023	

19. FINANCE AND REIMBURSEMENT

D. Third-Party Liability

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP and its Delegates ensure any potential Third-Party Liabilities (TPLs) are reported to the California Department of Health Care Services (DHCS).[1] DHCS has the right to recover funds related to services paid by Medi-Cal for injuries a Member sustains, for which a Member receives a settlement, judgment or award for a liable third party for those same injuries.

B. Department of Health Care Services (DHCS) has sole rights to impose liens in TPL tort actions or claims involving Medi-Cal Members. Instances that may give rise to tort liability include but are not limited to, auto accidents, slip and falls, animal attacks, product or premises liability, medical malpractice, class actions and Workers' Compensation claims.

DEFINITION:

A. Delegate - An organization authorized to perform certain functions on IEHP's behalf.

B. Third Party Liability (TPL) - The legal obligation of third parties to pay part or all of the expenditures for medical assistance furnished under a Medicaid State Plan.

PROCEDURES:

A. Delegates must assist IEHP in identifying and notify the IEHP Actuarial Department of cases in which an action of a third party could result in recovery of funds by the Medi-Cal Member.

B. IEHP is required to report cases involving TPL to DHCS within 10 calendar days of discovery using the DHCS Personal Injury Program form found online at https://www.dhcs.ca.gov/services/Pages/TPLRD_PersonalInjuryProgram.aspx.[2]

C. If IEHP requests payment information and/or copies of paid invoices/claims for Covered Services to a Medi-Cal Member, Delegates must deliver the requested information to IEHP via email.

D. When DHCS requests service and utilization information for IEHP Medi-Cal Members injured by a third party, IEHP will communicate with Delegates separately to confirm the list of services made by the Delegate to the injured Member and request responses within 21 calendar days. A combined list will then be submitted to DHCS by IEHP within 30 calendar days.[3]

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 21-007 Supersedes APL 17-021, "Third Party Tort Liability Reporting Requirements"
[2] DHCS APL 21-007
[3] Ibid.

19. FINANCE AND REIMBURSEMENT

D. Third-Party Liability

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

19. FINANCE AND REIMBURSEMENT

E. Public and Private Hospital Directed Payment Program

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Hospital Providers.

POLICY:

A. IEHP participates in the Designated Public Hospital (DPH) Enhanced Payment Program (EPP), the Designated Public Hospital (DPH) Quality Incentive Pool (QIP), the District and Municipal Public Hospital (DMPH) Quality Incentive Pool (QIP), and the Private Hospital Directed Payment (PHDP) programs in accordance with terms approved by the Centers for Medicare & Medicaid Services (CMS).[1]

PURPOSE:

A. To describe the payment process and how to access the funds for the DPH EPP, DPH QIP, DMPH QIP and PHDP programs, as described in this policy.

PROCEDURES:

A. **Payment Process and Other Provisions**

1. DHCS will calculate IEHP's payment obligation to Network Provider Hospitals eligible for DPH EPP, DPH QIP, DMPH QIP, and PHDP directed payments in accordance with the CMS-approved preprints and Welfare and Institutions Code (WIC) § 14197.4(b). DHCS will provide IEHP's its payment obligations to eligible Network Provider Hospitals, and the projected value of the payment obligations will be accounted for in IEHP's capitation rates.[2]
2. IEHP must ensure that any payment obligations under DPH EPP, DPH QIP, DMPH QIP, and PHDP are discharged by IEHP or by its Subcontractors timely after IEHP receives revenue from DHCS accounting for the projected value of the payment obligations.[3]
3. The Finance Analytics team will provide report and signed Payment Attestation no later than three (3) months after the month in which the revenue is received confirming that all payments required under DPH EPP, DPH QIP, DMPH QIP, and PHDP have been made. The report and Payment Attestation will be signed by the Chief Financial Officer.
4. When IEHP receives DHCS' Payment Exhibits for the Hospital Directed Payment (HDP), the IEHP Finance Team prepares for Providers' payment distribution. The Finance Team

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 21-018, "Public and Private Hospital Directed Payment Programs for State Fiscal Years 2017-2018 and 2018-19, the Bridge Period, and Calendar Year 2021"
[2] DHCS APL 21-018
[3] Ibid.

acknowledges HDP funding from DHCS is received, reconciles the funds to IEHP capitation rates for the PDHP, EPP, and QIP, and the total payment materially ties to the total payment in the Payment Exhibit files. Any material discrepancy uncovered is followed up and resolved with DHCS before payment is distributed. Once the reconciliation process is complete, a payment file is prepared that consolidates the Payment Exhibit files by Provider Name, Payment Type (PHDP, EPP or QIP), Dates of Services, and the Amount. The file is forwarded to the Accounts Payable Team for processing. Provider Letter are prepared and sent to all Providers receiving payment with information on the type of payment, dates of services, and the paid amount. Payment is typically distributed to Providers within three to four (3-4) weeks of IEHP's completion of payment reconciliation.[4]

5. DHCS reserves the right to exercise its discretion under the IEHP contract to impose a corrective action plan or other remedies and sanctions on IEHP if it fails to submit the report and attestation or fail to make all payments in the manner required by DHCS.[5]

B. **Designated Public Hospital (DPH) Enhanced Payment Program (EPP)**

1. DPH EPP provides supplemental reimbursement to Network Provider DPHs through uniform dollar increases for select inpatient and non-inpatient services, based on the actual utilization of qualifying services as reflected in encounter data reported to DHCS. In addition, for Network Provider DPHs that are primarily reimbursed on a capitated basis, DPH EPP provides supplemental reimbursement through uniform percentage increases to their contracted capitation rates.[6]

2. DPH EPP utilization-based payments and Capitation based payments will be calculated by DHCS in accordance with the CMS-approved preprint and must be issued by to DPHs, in six-month increments: January through June, and July through December.[7]

3. IEHP are directed to increase payment to DPHs for qualifying contracted services or assigned Member months in accordance with the CMS-approved preprint and Welfare and Institutions Code (WIC) Section 14197.4(b).[8]

C. **Designated Public Hospital (DPH) Quality Incentive Pool (QIP)**

1. DPH QIP provides quality incentive payments to participating network Providers DPHs that meet quality metrics designated in the program. DPH QIP payments will be calculated by DHCS in accordance with CMS approved preprint and must be issued to

[4] DHCS APL 21-018
[5] Ibid.
[6] Ibid.
[7] Ibid.
[8] Ibid.

DPHs based on the program year. IEHP is required to comply with the data sharing requirements.[9]

D. **Private Hospital Directed Payment Program (PHDP)**

1. PHDP provides supplemental reimbursement to participating Network Provider private hospitals through uniform dollar increases for select inpatient and outpatient services based on actual utilization of qualifying services as reflected in encounter data reported to DHCS.[10]
2. PHDP utilization-based payments will be calculated by DHCS in accordance with the CMS approved preprint, and must be issued by IEHP to private hospitals, in six-month increments: January through June, and July through December.[11]

E. **District and Municipal Public Hospital (DMPH) Quality Incentive Pool (QIP)**

1. DMPH QIP provides quality incentive payments to participating Network Providers DMPHs that meet quality metric designated in the program. DMPH QIP payments will be calculated by DHCS in accordance with the CMS-approved preprint and must be issued to DMPHs based on the program year.[12]

F. **District Hospital Directed Payment Program (DHDP)** Beginning with the January 1, 2023, rating period, DHCS has directed MCPs to reimburse California's District Municipal Hospitals for network contracted services delivered by DMPH systems, based on actual utilization of contracted services for select inpatient, long term care and Outpatient services. The payments will be enhanced by a uniform dollar increment.

G. **PHDP/EPP Dispute Inquiries**

1. IEHP will send a letter of acknowledgement by email to accept, acknowledge. and to resolve Hospital disputes related to the processing or non-payment of DPH EPP, DPH QIP, DMPH QIP, or PHDP directive payments. Letter of acknowledgement are sent to Hospital within 48 hours of receipt and is resolved within thirty (30) calendar days of receipt of dispute received via email.
2. The Finance Analytics Team enters disputes into department tracking log. Inquiries about payment and encounter disputes can be emailed to PHDP-EPPinquiry@iehp.org.

H. **Exclusions**

1. DPH EPP payments are **not applicable** to inpatient services provided to Members with Medicare Part A, non-inpatient services provided to Members with Medicare Part B, and

[9] DHCS APL 21-018
[10] Ibid.
[11] DHCS APL 21-018
[12] Ibid.

state-only abortion services. DPH EPP also excludes services provided by Cost-Based Reimbursement Clinics (CBRCs), Indian Health Care Providers (IHCPs), Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs).[13]

2. PHDP payments are **not applicable** to inpatient services provided to Members with Medicare Part A, outpatient services provided to Members with Medicare Part B, and state-only abortion services. PHDP also excludes services provided by CBRCs, IHCPs, FQHCs, and RHCs.[14]

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	☐ DMHC	☐ NCQA
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[13] DHCS APL 21-018
[14] Ibid.

19. FINANCE AND REIMBURSEMENT

F. Medi-Cal Capitation – IPA and IEHP Direct Providers

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal IPAs and IEHP Direct PCPs.

POLICY:

A. IEHP delegates the responsibility of providing medical services for its Members to its IPAs and 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 IPA and the PCP for Members assigned to that organization.

B. The capitation is paid on a Per Member Per Month (PMPM) basis according to the Member's Category of Aid (COA) and assigned IPA for IPAs, and the Member's Category of Aid (COA) and age for PCPs. The Capitation is paid in full to the IPA and the PCP 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 and the PCP.

C. Capitation is paid monthly to each IPA and PCP/Medical Group for all of their assigned Members. The payments are 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 for the current month is paid at the end of the month for Members with active eligibility as of the 15th of the current month. For members who are enrolled and assigned to a network IPA or PCP/Medicare Group during the current month, capitation shall be payable as of the date of assignment and will be paid within 30 days of that date of assignment.

E. It is the responsibility of the IPA and the PCP to provide or arrange for services that are the financial responsibility of the IPA and the PCP.

PROCEDURES:

A. IEHP calculates capitation payments for each IPA and the PCP based on the current (new) month's membership and any retroactive adjustments.

B. Each month IEHP creates a capitation file for IPAs 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 (for file format information see Attachment, "Capitation Data File Format" in Section 19, or refer to the IEHP Provider Electronic Data Interchange (EDI) Manual). Files for PCPs are accessible from the Secure Provider Website by the first of the month for the prior month's capitation.

C. To reconcile the amount paid each month, IPAs and PCPs should review the electronic cap files and capitation reports provided by IEHP (See Attachments, "Capitation Data File Format" and "Sample Capitation Report" in Section 19).

19. FINANCE AND REIMBURSEMENT

F. Medi-Cal Capitation – IPA and IEHP Direct Providers

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