19. FINANCE AND REIMBURSEMENT

A. Financial Viability
   1. IPA

APPLIES TO:

A. This policy applies for 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 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 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 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.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 Ibid.
19.  FINANCE AND REIMBURSEMENT

A.  Financial Viability

1.  IPA

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 hundred fifty (150) days after the end of the IPAs 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 conditions 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 statements submitted by the IPAs to ensure the following IEHP financial viability standards/requirements are met at all times:

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. **Financial Viability**

1. **IPA**

7. Medical Expense Ratio is always less than 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;

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; and

11. IBNR calculation worksheets that support the amounts represented on the financial statements accompany all submissions. IPAs must provide the following as well:
   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 must 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. Financial Viability
   1. IPA

   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:

<table>
<thead>
<tr>
<th>IPA’s enrollment</th>
<th>Deposit Requirement</th>
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<tbody>
<tr>
<td>Up to - 10,000</td>
<td>$100,000.00</td>
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<tr>
<td>10,001 - 20,000</td>
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<td>90,001 plus</td>
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</table>

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 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.

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.

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19. FINANCE AND REIMBURSEMENT

A. Financial Viability
   1. IPA

Q. 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.

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

T. In the event a 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 a IPA.
19. FINANCE AND REIMBURSEMENT

A. Financial Viability

2. Hospital

APPLIES TO:

A. This policy applies to all Hospitals contracted with IEHP under a Capitated Agreement.

POLICY:

A. IEHP complies with all regulatory requirements to protect its Members from the consequences of financial failure of an IEHP contracted hospital.

B. IEHP has established financial viability standards to ensure all capitated hospitals are financially sound and can handle the risks associated with capitation.

C. IEHP requires all capitated hospitals to meet IEHP’s financial viability requirements.

D. All financial viability requirements must be met prior to any assignment of Members to the hospital with ongoing conformance with the requirement.

PROCEDURES:

A. Prior to entering into a contractual agreement with IEHP and annually thereafter, capitated hospitals must submit their most current audited financial statements comprising Balance Sheets, Income Statements, Statements of Cash Flow and supporting worksheets for incurred, but not reported (IBNR) or IBNR certification by an independent, certified actuary mutually acceptable to IEHP. The financial statements must demonstrate that the hospital is financially viable and able to meet IEHP’s financial viability standards/requirements. IEHP does not enter into Capitated Agreements with hospitals that do not meet these standards.

B. On an annual basis, all contracted hospitals are required to submit a copy of their annual audited financial statements, including IBNR certification to IEHP for compliance review no later than one hundred fifty (150) days after the end of the hospitals’ fiscal year.

C. Financial statements must clearly display the financial condition of the entity contracted with IEHP. Subject to the following conditions, the submission of consolidated or parent company financial statements in good form are acceptable to IEHP. Consolidated financial statements are acceptable if the financial condition of the contracted entity is clearly stated. Typically, consolidating work papers supporting the consolidated statements are required. A parent company’s financial statements are acceptable in lieu of the contracted entity’s, if IEHP has accepted the parent company’s financial guarantee of the subsidiary.

D. IEHP reviews the financial statements submitted by the hospital to ensure the following financial viability standards are met at all times:

1. Tangible Net Equity equals no less than $1 million at all times;

2. The Current Ratio (the ratio of current assets to current liabilities) always exceeds 100%; and
19. FINANCE AND REIMBURSEMENT

A. Financial Viability

2. Hospital

3. IBNR calculation worksheets that support the amounts on the financial statements accompany all submissions.

E. IEHP may request interim financial statements and supporting information upon written notice to the hospital.

F. If the hospital fails to meet any of the above referenced standards, IEHP may take the following actions:
   1. Freeze the hospital to new membership;
   2. Place the hospital in contractual cure for breach of contract;
   3. Seize any capitation and risk pool monies owed until breach is cured; or
   4. Immediately terminate the IEHP/Hospital Agreement for cause and convert to a Per Diem Agreement.

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.
19. FINANCE AND REIMBURSEMENT

B. Medi-Cal Capitation – IPA

APPLIES TO:

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

B. The capitation is paid on a Per Member Per Month (PMPM) basis according to the Member’s Adjusted Clinical Group (ACG) score, aid code category, age, gender, and Medicare status. The Capitation is payment 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 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 California Department of Health Care Services (DHCS).

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 for each IPA based on the current (new) month’s membership and any retroactive adjustments.

B. Capitation payments are sent via EFT to the IPA 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 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 (for file format information see Attachment, “Capitation Data File Format” in Section 19, or refer to the IEHP Provider Electronic Data Interchange (EDI) Manual).

D. To reconcile the amount paid each month, IPAs 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).
B. Medi-Cal Capitation – IPA

<table>
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<th>INLAND EMPIRE HEALTH PLAN</th>
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<tr>
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<tr>
<td><strong>Chief Title:</strong> Chief Operating Officer</td>
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</tbody>
</table>

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Page 2 of 2
C. Pay For Performance

**APPLIES TO:**

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

**POLICY:**

A. The IEHP’s Pay for Performance Program (P4P), was 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 assessment visits with an emphasis on review and management of chronic illness.

B. Under P4P, effective January 1, 2021 only contracted and credentialed IEHP Direct Primary Care Providers (PCPs) are eligible to receive compensation for Medicare DualChoice Annual.

C. PCPs are automatically enrolled in P4P upon completion of IEHP’s credentialing process, designation of an effective date for participation in the IEHP network and initial Provider inservices completion. Request for Taxpayer Identification Number and Certification (Form W-9) information verified during the credentialing process will be used for remittance of P4P payment.

D. 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.

E. **Providers must submit online only at www.iehp.org.** IEHP will not accept or reimburse initial paper submissions made via mail or fax except corrective resubmission only.

F. Medicare DualChoice Annual Visit must be submitted online only at www.iehp.org using the appropriate form. All the Member’s significant conditions/diagnoses must be assessed 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. Completed annual visit forms must be submitted online to IEHP within two (2) months from the date of service and must meet IEHP’s submission standards to qualify for the incentive. 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.

G. The OB/GYN Quality Pay-for-Performance (P4P) program provides an opportunity for IEHP’s OB/GYN Providers to earn a financial reward for improving the quality of maternity care for IEHP’s pregnant and postpartum Members. The OB/GYN Quality P4P Program includes performance-based incentives for the provision of specific prenatal and postpartum services. Payments will be administered for select services performed by eligible Providers to IEHP Members who meet the program criteria. The OB/GYN P4P program is designed to support OB/GYN practices to earn financial incentives for quality performance. See the 2020 Pay for Performance (P4P) Program Technical Guide at
H. 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. Measures are listed below, in alphabetical order, and technical specifications and details for each P4P measure are included in the Appendix of the 2020 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.
   a. Initial Prenatal Visit
   b. Perinatal Chlamydia Screening
   c. Perinatal Depression Screening
   d. Postpartum Blood Pressure Screening
   e. Postpartum Diabetes Screening
   f. Early Postpartum Visit
   g. Later Postpartum Visit
   h. Tdap Vaccine

I. IEHP conducts on-going audits of P4P Providers for compliance with Pay for Performance program requirements, including submission accuracy, completeness of forms, and supporting documentation in the Member’s medical record for P4P submissions.

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 Medicare DualChoice Annual Visit component and OB/GYNs participating in the OB/GYN Quality P4P program.

PROCEDURES:

A. The following outlines each component included in the P4P Program, including participation details and reimbursement requirements.
   1. Medicare DualChoice Annual Visit
19. FINANCE AND REIMBURSEMENT

C. Pay For Performance

a. Effective January 1, 2021, only credentialed IEHP Direct PCP participating in IEHP DualChoice Program are eligible to participate in the Medicare DualChoice Annual Visit component.

b. Only IEHP DualChoice Members are eligible for the Medicare DualChoice Annual Visit.

c. The goal of the Medicare DualChoice Annual Visit component is to ensure that IEHP DualChoice Members receive timely annual visit with emphasis on chronic illness.

d. Participating IEHP Direct PCPs must record significant chronic diagnoses and document history and physical findings related to these diagnoses in the medical record.

e. The new individual Member specific IEHP DualChoice form is available through the Member Eligibility Webpage. A copy of this form must be printed prior to the Member’s visit.

f. 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.

g. Participating IEHP Direct PCPs are paid $200 each annual Visit they provide to an eligible IEHP DualChoice Member. The incentive is paid in addition to your FFS visit reimbursement or your capitated PCP agreement.

h. Only one (1) exam per year qualifies for this incentive, regardless if the IEHP DualChoice Program Member has had several PCPs and multiple exams.

i. Annual visit performed must be submitted online at www.iehp.org and indicate the appropriate ICD codes for the visit within two (2) months from date of service. Failure to submit within the required timeframe may result in non-reimbursement.

j. Reimbursements are made within thirty (30) working days of receipt of a complete Medicare DualChoice Annual form submitted online.

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

a. 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.

b. IEHP’s Medi-Cal and IEHP DualChoice Members who are pregnant are eligible for the OB/GYN Quality P4P Program.

c. The goal of the IEHP OB/GYN Quality P4P program is to improve the quality of maternity care for IEHP’s pregnant and postpartum Members.

d. Providers must complete and submit codes with required modifiers for P4P services by means of electronic claim submission (CMS-1500) to IEHP via their
19. FINANCE AND REIMBURSEMENT

C. Pay For Performance

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 services (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.

e. 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 summary remittance advice reports with each payment distribution (See Attachments, “Remittance Advice – Medicare DualChoice Annual Visit” and “Remittance Advice – Perinatal” in Section 19). To access Remittance Advice (RAs) online, log on to the secure site login at www.iehp.org.

2. Detailed activity reports are also included with reimbursements made for the Well Child and Immunization components (See Attachment, “P4P Detail Activity Report – IEHP DualChoice” in Section 19).

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.

5. Providers not responding to CAP requests are subject to removal from participation in P4P.
19. FINANCE AND REIMBURSEMENT

C. Pay For Performance

6. Depending on the nature and severity of the findings and the Provider’s response, IEHP may take action 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.
   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 16B2, “Grievance 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/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. You may also file an Appeal within one hundred and twenty (120) days from the claim determination date.

2. P4P Providers of service must attached a cover letter clearly indicating the reason for the appeal or you may complete the Provider Dispute Resolution request form that can be downloaded online at www.iehp.org.

3. For Dual Choice Annual P4P and 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.
19. FINANCE AND REIMBURSEMENT

C. Pay For Performance
APPLIES TO:
A. This policy applies to all IEHP Medi-Cal Members.

POLICY:
A. Delegates must not make a claim for recovery of the value of covered services rendered to a Medi-Cal Member when such recovery would result from an action involving the tort liability of a third party or casualty liability insurance, including Workers’ Compensation awards and uninsured motorists coverage.

B. Department of Health Care Services (DHCS) has sole lien rights for such recoveries. Delegates must assist IEHP in identifying such cases to DHCS and must respond to any DHCS or IEHP generated request for claims information within ten (10) business days of receipt of such request.

DEFINITION:
A. Delegate is defined as an organization authorized to perform certain functions on IEHP’s behalf.

PROCEDURES:
A. Delegates must identify and notify the IEHP Financial Analysis Department of cases in which an action of a third party could result in recovery of funds by the Medi-Cal Member.

B. IEHP must report such cases to DHCS within ten (10) days of discovery.

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.
19. FINANCE AND REIMBURSEMENT

E. IPA Financial Supervision

APPLIES TO:

A. This policy applies for 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 to 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 Service Organization (MSO) contract.

¹ Title 28 California Code of Regulations (CCR) §1300.75.4.2.
² Ibid.
19. FINANCE AND REIMBURSEMENT

E. IPA Financial Supervision

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 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); and

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 (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 be review financial and other statements, including bank statements and/or other records to ensure payments are made and checks have been cleared.
19. FINANCE AND REIMBURSEMENT

Attachments

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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.

**Element: 16 & 21**

**Note # 16 & 21:** Member Aid Code and Member Category of Aid
## Capitation Data File Format Element Descriptions

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### Eligibility Data File Format

Revision Date 01/01/21

Page 3 of 4
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 (blank). 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
IRREVOKEABLE STANDBY LETTER OF CREDIT FOR INCLUSION IN THE PROVIDER NETWORK OF THE INLAND EMPIRE HEALTH PLAN

BENEFICIARY: Inland Empire Health Plan
Governed 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:
   “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 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: ________________________________

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**Summary Page**

- Total Number Of Claims: 5
- Total Payment Amount: $200.00

**Explanations Code Legend**

- P4P: Pay For Performance Program
Please Note:

Medi-Cal and Healthy Kids

- Under the Knox-Keele Act, Health and Safety Code 1379 of the State of California and Title 23 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 claims by logging into the Provider Portal at www.iehp.org. To obtain website instructions, please call IEHP Provider Relations Team at (909) 890-2064.
- In compliance with AB 1455, if you disagree with your payment, you may contact the IEHP Provider Relations Team at (909) 890-2054 or (866) 223-4347 Monday – Friday 8:30 am to 5:00 pm 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 4416, Rancho Cucamonga, CA 91729. Please visit www.iehp.org to obtain Provider Dispute Resolution form online.
- In accordance with our agreement, negative balances will be offset against future claims to be paid 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 10/21/11 to 12/31/11 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 claims by logging into the Provider Portal at www.iehp.org. To obtain website instructions, please call IEHP Provider Relations Team at (909) 890-2064.
- In accordance with our agreement, negative balances will be offset against future claims to be paid you.
- Appeals and Payment Dispute Requests – can be submitted within the timeframe indicated in your contract(s): 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 66-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/Medicare-coverage-reqs/Medicare-coverage-reqs-and-guidance/
- 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. A Non Contracted Provider you also have the option of sending your dispute to CDC Solutions Inc. For further information check the website regarding this process at PDR@CDCInc.com.

Legal Notice

- Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit 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.
## IPA Capitation
### April 2019

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<td>Total</td>
<td>165,984</td>
<td>$9,940,567.76</td>
<td>791</td>
<td>$30,775.87</td>
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Report:/CapSoft E Cap/Diamond/Providers/IPA_Cap_Summary_rpt
System: CapSoft

Department: Financial Analysis
Frequency: Monthly
## IPA Capitation
### April 2019

### Monthly Totals

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<td>166,775</td>
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Department: Financial Analysis
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