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 funding requirements to ensure all contracted IPA's 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]

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 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 an RBO within five (5) business days after the due date.[3] 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

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

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 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 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).[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.
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.

[4] 28 CCR §1300.75.4.2
[5] 28 CCR §1300.76

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.
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 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 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:

[6] International Standby Practices 1998, ICC Publication No. 590

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 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.

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;
   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.

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

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.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief Operating Officer	**Revised Date:**	January 1, 2023

19. FINANCE AND REIMBURSEMENT

B. IPA Financial Supervision

APPLIES TO:

A. This policy applies 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) 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. IPAs 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 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. Freezing 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.

      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.

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 (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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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.

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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 ten (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 twenty-one (21) calendar days. A combined list will then be submitted to DHCS by IEHP within thirty (30) calendar days.[3]

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[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.

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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 Provider Contracting Services 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] (See Attachment, "Payment Attestation" in Section 19)

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[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.
[4] DHCS APL 21-018

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 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.[5]

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.[6]

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.[7]

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.[8]

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).[9]

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

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

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 DPHs based on the program year. IEHP is required to comply with the data sharing requirements.[10]

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.[11]
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.[12]

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.[13]

F. **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 forty-eight (48) hours of receipt and is resolved within thirty (30) calendar days of receipt the Hospital Directed Payment Dispute form. (See Attachment, "Hospital Directed Payment Dispute Form" in Section 19) The Hospital must complete the Hospital Directed Payment Dispute form and submit it along with the Manifest Report with all encounters in question. (See Attachment, "Manifest Report" in Section 19).[14]

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

2. The Provider Contracting Services Team enters disputes into the WorkFront system.[15] Inquiries about payment and encounter disputes can be emailed to PHDP-EPPinquiry@iehp.org.

G. **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 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).[16]

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.[17]

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[15] DHCS APL 21-018
[16] DHCS APL 21-018
[17] Ibid.

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).

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19. FINANCE AND REIMBURSEMENT

Attachments

DESCRIPTION	POLICY CROSS REFERENCE
Capitation Data File Format	19B
Hospital Directed Payment Dispute Form	19E
Irrevocable Letter of Credit	19A
Manifest Report	19 E
Payment Attestation	19 E
Remittance Advice – Medicare DualChoice Annual Visit	19C
Sample Capitation Report	19B

#	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

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.

Element: **16 & 21**

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

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		20	0L	7U		
23	02	0E	4W		24	0M	L1		
53	03	2C	5C		26	0N	M1		
63	04	2P	5D		27	0P			
	06	2R	5K		2E	0R			
	07	2S	5L		2H	0T			
	08	2T	5V	P9	36	0U			
	30	2U	7A			0W			
	32	2V	7J	R1		10			
	33	3A	7S		60	14			
	34	3C	7W		64	16			
	35	3E	7X		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						

Element: 20
Note # 20: Member Group

MEDI-CAL RIVERSIDE	MEDI-CAL SAN BERNARDINO	Medicare RIVERSIDE	Medicare SAN BERNARDINO
RVC-MED RVC-MMD RVC-CCI	SBC-MED SBC-MMD SBC-CCI	IEHP DualChoice	IEHP DualChoice

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

INLAND EMPIRE HEALTH PLAN

Hospital Directed Payment Dispute Form

INSTRUCTIONS:

Please complete the below form. Fields with an asterisk (*) are required. Provide additional information to support the description of the dispute

For routine follow-up status, please call the IEHP Provider Team at (909) 890-2054 or (866) 223-4347 Monday-Friday 8:00 am to 5:00 pm PST

Please email completed form to PHDP-EPPinquiry@iehp.org. IEHP will acknowledge dispute within 48 hours with a resolution within 30 business days from dispute receipt date.

*Hospital Name:	*Hospital NPI #:	*Hospital Tax ID #
*Dispute Type: ☐Non-Payment ☐Underpayment	*Program Phase:	*Program ☐EPP ☐PDHP

*Description of Dispute:

In addition to description please also provide a spreadsheet with the below data elements for all encounters in question.

INLAND EMPIRE HEALTH PLAN

Attachment 19 – Hospital Directed Payment Dispute Form

*Claim ID	*PCN	*Service Dates		*Claim type Inst/Prof	*Patient Name First,Last	DOB	*IEHP Subscriber ID	*IPA Name If IPA Encounter	*IPA Claim Number
		Start	*End*						

Contact Name (please print) | **Title** | **Phone Number**

Signature | **Date** | **Fax Number**

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 exist 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 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, 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 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:____

____

HospitalName	ClaimType	HospClaimNo	DCN	IEHPClaimNo	BillType-POS	COS	PatientLName	PatientFName	AdmitDate
Hospital A	Institutional	ABC123	123456789	0000E0000000001	13	OP	Doe	John	2/12/2018
Hospital A	Institutional	ABC124	256874156	0000E0000000002	11	IP	Doe	Jane	3/5/2018
Hospital A	Institutional	ABC125	258746312	000123456	23	ER	Mouse	Mickey	4/5/2018

DschDate	StatementDate	BirthDate	SubscriberID	CIN	PaidAmt	IPA	IPA_ClaimNo	BillProvNPI
2/14/2018	2/12/2018 - 2/14/2018	1/1/1950	2012123456789	123456789A	3330	IPA X	NULL	123456789
3/6/2018	3/5/2018 - 3/6/2018	2/2/2010	2010020212331	123456711A	2500	None	NULL	132123132
4/7/2018	4/5/2018 - 4/7/2018	2/3/2000	2000020333333	123456719A	2600	None	NULL	213212123

In compliance with APL 21-018, IEHP acknowledge and confirm payment obligations under DPH EPP, DPH QIP, DMPH QIP, and PHDP have been issued timely. The following is the summary of the payments that have been issued. Enclosed is the corresponding detailed payment reports.

Payment Attestation

Program/SFY	Payment Amount	Payment Issued Date	Notes

Chief Financial Officer,
Keenan B. Freeman

_______________________ _______________________ _______________
Title and Name Signature Date

Completed form will be sent via email to plandp@dhcs.ca.gov.

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	03/16/2018	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	03/16/2018	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	03/16/2018	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	03/16/2018	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 theCalifornia Code of Regulations, the patient to whom services were provided is not liable for any portionof 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 ProviderDispute within 365-days from the claim determination date. Disputes should be submitted to IEHP ClaimsAppeals Resolution Unit P.O. Box 4319, Rancho Cucamonga, CA 91729. Please visit www.iehp.org to obtaina Provider Dispute Resolution form online.
- In accordance with our agreement, negative balances will be offset against future claims to be paidto 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) bylogging 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 contractto: 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 ofLiability and any supporting documentation within 60-days from the denial date. The waiver ofliability 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 anysupporting documentation within 120-days from the initial determination date. As a Non Contracted Provideryou also have the option of sending your dispute to C2C Solutions Inc. For further information check theirwebsite 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 orknowingly presents false information in an application for insurance may be guilty of a crime and may be subjectto 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 fromthe Member in addition to the IEHP card.

INLAND EMPIRE HEALTH PLAN

IPA Capitation

April 2019

Group	COA	Current Month		Retroactivity		Sub Total	
		Enrollment	Capitation	Enrollment	Capitation	Enrollment	Capitation
RVC-MED	Adult	18,321	$1,312,758.45	56	$3,139.32	18,377	$1,315,897.77
	BCCTP	8	$2,731.20	0	$0.00	8	$2,731.20
	Child	34,239	$972,387.60	111	$3,152.40	34,350	$975,540.00
	LTC - Non Dual	2	$0.00	5	$0.00	7	$0.00
	MCE - Non Dual	30,892	$2,337,759.98	115	$2,647.25	31,007	$2,340,407.23
	SPD	4,844	$645,129.00	33	$5,842.64	4,877	$650,971.64
	Sub Total	**88,306**	**$5,270,766.23**	**320**	**$14,781.61**	**88,626**	**$5,285,547.84**
SBC-MED	Adult	14,836	$1,114,143.17	133	$10,066.82	14,969	$1,124,209.99
	BCCTP	4	$1,106.99	0	$0.00	4	$1,106.99
	Child	33,474	$950,661.60	237	$6,730.80	33,711	$957,392.40
	LTC - Non Dual	8	$0.00	1	$0.00	9	$0.00
	MCE - Non Dual	24,457	$1,864,541.69	61	($5,491.59)	24,518	$1,859,050.10
	SPD	4,899	$739,348.08	39	$4,688.23	4,938	$744,036.31
	Sub Total	**77,678**	**$4,669,801.53**	**471**	**$15,994.26**	**78,149**	**$4,685,795.79**
Total		**165,984**	**$9,940,567.76**	**791**	**$30,775.87**	**166,775**	**$9,971,343.63**

IPA Capitation

April 2019

Monthly Totals

	Current	Retro	Total
Enrollment	165,984	791	166,775
Capitation	$9,940,567.76	$30,775.87	$9,971,343.63
Adjustments			
	Claims Decap		($176.62)
	Risk Adjustment Additional Funding		$183,128.96
	Paid on the 15th		$0.00
	Prior Month Adjustment		$0.00
Check Amount			$10,154,295.97