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SECTION 11: PROVIDER PAYMENT

PROVIDER PAYMENT

HPSJ wants to ensure that Providers are reimbursed in a timely and accurate manner. To assist in this, please note the following:

W-9 FORMS

In order to ensure the correct reporting of Provider income to the Internal Revenue Service (IRS) and the California Franchise Tax Board, it is essential that HPSJ have an accurate and current W-9 form on file. The information on the W-9 provides HPSJ with the following:

- The entity being paid
- The address where payments are to be directed
- The tax ID number that should be used to report the income you receive from us

The sections of the W-9 that are of key importance are:

- **Legal Name** – This is the name of the individual or the name of the filed corporation that will appear on the Provider's tax return.
- **Business Name** – This is the name under which the Provider does business. Many times a company will have a Doing Business As (DBA) name. This name is used instead of the legal name for general business purposes.

FEDERAL 1099 FORMS

Providers who are paid less than six hundred dollars ($600) during the tax year are not issued a 1099. If a 1099 is received from HPSJ and the information is incorrect, please contact the Provider Services Department at (209) 942-6340. A corrected 1099 will be printed and mailed within five (5) business days.

CAPITATION PAYMENTS

Capitation is the "per-Member-per-month" (PMPM) payment that is paid based on the Provider's Agreement. This fixed monthly reimbursement is paid primarily to PCPs as full reimbursement for specified Covered Services provided to each Member assigned. Capitated Providers should receive their monthly capitation checks by the tenth (10th) of each month. Capitation Payments can be made by check or direct deposit to Providers' bank accounts. See information below on how to set up electronic funds transfer (EFT).

SECTION 11: PROVIDER PAYMENT

CAPITATION REPORTS

The monthly capitation checks are accompanied by a remittance advice (RA) which identifies assigned Members for which Capitation Payments are made. Since monthly Capitation Payments are paid in advance, it is sometimes necessary to adjust payments retroactively due to Member enrollment fluctuations throughout the month. These adjustments are made in the following month's Capitation Payment. For example, if a Provider is paid for one hundred (100) assigned Members for a particular month but four (4) Members either become assigned to another Provider or disenrolled from the plan during the month, the following month's capitation report and Capitation Payment would show the payment adjustment for the four (4) disenrolled Members based on their date of termination. Similarly, if four (4) Members were added to a Provider's panel during the month, these additions would be detailed on the capitation report and adjusted in the following month's Capitation Payment.

FEE-FOR-SERVICE PAYMENT AND REMITTANCE ADVICE (RAS)

Fee-for-service payment would apply to any Covered Services that are provided by non-capitated Providers or for non-capitated Covered Services that are provided by capitated Providers. Fee-for-service claims can be submitted by any Provider who provides Authorized Covered Services to an HPSJ Member under their Agreement. Please note however that not all services a Provider might perform are reimbursable under the Medi-Cal contract between the State and HPSJ. Unauthorized services and non-Covered Services may be denied.

HPSJ will issue a Remittance Advice (RA) to all Providers who submit claims for payment. The RA explains the status of claims that were processed and sorts claims in the following order:

- Claim type
- Claim status (paid, denied, adjustments, interest and penalties)
- Internal Control Number (ICN).

If Providers have not specifically requested payments be transferred directly into a bank account through Electronic Funds Transfer (EFT), a check for the total amount of paid claims represented on the RA will be mailed.

If the amounts on your RA and check do not match or if a duplicate RA is needed, please contact the Provider Services Department at (209) 942-6340.

PAYMENT DELAYS RELATED TO PROVIDER DIRECTORY

Consistent with Section 1367.27 of the Health and Safety Code, HPSJ may delay claims and Capitation Payments if Providers fail to respond to attempts to verify the information needed to update the Provider Directory. HPSJ will not delay payment unless it has attempted to first verify

the Provider's information by contacting the Provider in writing, electronically, or by telephone to confirm whether or not the current information is correct or requires updating. If Providers receive Capitation Payments, HPSJ may delay up to fifty percent (50%) of payment for up to one (1) calendar month beginning on the first (1st) day of the following month. For Providers submitting fee-for-service claims, payment can also be delayed for up to one (1) calendar month beginning on the first (1st) day of the following month.

HPSJ will provide ten (10) business days' notice prior to delaying payment. If payment is delayed, HPSJ will reimburse the full amount within three (3) business days following the date the Provider Directory information is received, or at the end of the one (1) month delay period.

ENCOUNTER DATA SUBMISSION

PCPs receiving Capitation Payments are required under the terms of their Agreements to submit Encounter Data to HPSJ on a monthly basis. This important data is used by HPSJ, CMS, and DMHC, and is essential. Data can be submitted easily by using a Form 1500 and may be submitted electronically. Data must be received by HPSJ no later than the fifteenth (15th) of the month following the date services are rendered

ELECTRONIC FUNDS TRANSFER (EFT)

Electronic Funds Transfer (EFT) is a great way to expedite payment receipt from HPSJ. To take advantage of this service, please contact Emdeon at (877) 469-3263 or online at www.emdeon.com/EFT. If you need more information, please contact the Provider Services Department at (209) 942-6340.

CHECK TRACERS

If payment has not been received within thirty (30) days of the check issue date, the Provider Services Department should be contacted at (209) 942-6340 in order to complete an affidavit to initiative a check tracer. An affidavit form is a written statement of facts voluntarily made by claimant under an oath or an affirmation administered by a person authorized to do so by law.

Provider Services staff will verify with the HPSJ Finance Department if the check is outstanding, has been cashed, or has been deposited. If the check has been cashed or deposited, the Provider will be contacted and provided a copy (front and back) of the paid check.

If the check has not been cashed or deposited, the Provider will be faxed or e-mailed the affidavit form to be completed and signed by an authorized person at the Provider's office. The completed affidavit form must be faxed to the Provider Services Department at (209) 461-2565.

Finally, a stop payment order will be placed on the check and a request to reissue the check will be placed on the next weekly check write. Providers will be notified within seven (7) business

days from the date when the stop payment was placed and informed as to the date they can expect the check to be reissued.

COORDINATION OF BENEFITS (COB)

When HPSJ is the secondary payer, all claims must be submitted within three hundred and sixty-five (365) days from the date of payment on the primary payer's Explanation of Benefits (EOB) form. A copy of the EOB must be attached to the claim if submitted via paper. COB data can also be submitted electronically if the claim is filed electronically. Medicare Part A and B claims must be submitted with the Explanation of Medicare Benefits (EOMB) form attached to the claim. If the Member's primary plan denies services and requests additional information, the information must be submitted to the primary insurance carrier prior to submitting to HPSJ.

THIRD PARTY LIABILITY (TPL)

HPSJ is responsible for notifying the Department of Health Care Services (DHCS) within ten (10) days of identifying cases in which a Member might receive funds from a third party to which DHCS has lien rights.

HPSJ must be notified in writing of all potential and confirmed third party liability cases that involve a HPSJ Member. Notification must include:

- Member name
- Member identification number and Medi-Cal number
- Date of birth
- Provider name and address
- Date(s) of service
- CMS approved diagnostic and procedural coding
- Billed charges for service(s)
- Any amount paid by other coverage (if applicable)
- Date of denial and reason(s) for denial

Any requests received by subpoena from attorneys, insurers, or Members for bill copies must be reported to HPSJ. Copies of the request and responses must be forwarded to:

Health Plan of San Joaquin
7751 S Manthey Rd,
French Camp, CA 95231-9802
Attn: Third Party Liability Coordinator

Upon receipt of a request for information from DHCS, HPSJ must respond within thirty (30) days. Providers will be contacted if their assistance if needed. The information requested from Providers must be returned within ten (10) days.

FACILITY PAYMENTS

HPSJ contracts with Facilities within the Service Area and provides access to specialty Facility services when needed outside of the Service Area. Each Facility Agreement contains specific reimbursement information indicating payment methodologies.

As a Medi-Cal plan, HPSJ will reimburse any Facility providers on staff using the Medi-Cal fee schedule. Neither contacted nor non-contracted facilities can balance bill Members for any Covered Services provided.

All Facility services require prior Authorization and Providers are expected to assist HPSJ's Medical Management staff by providing the Member information and medical documentation necessary to support high quality, timely, and cost effective health care.

No Payment for Never Events, Hospital Acquired Conditions (HAC), and Other Provider Preventable Conditions (OPPC)

The Centers for Medicare & Medicaid Services (CMS) defines Never Events as "serious and costly errors in the provision of health care services that should never happen." Never Events, HACs, and OPPCs can be avoided through the application of evidence based clinical guidelines. Institutional providers are encouraged to take appropriate actions to reduce the likelihood of Never Events, HACs, and OPPCs.

Facility providers will not be reimbursed for Covered Services related to or resulting from Never Events, HAC, or OPPC including reimbursement for additional Inpatient Days that would not have been incurred in the absence of such Never Event, HAC, or OPPC. These events shall not be included in either APR-DRG calculations, Per Diems, or included in any stop loss calculations.

In the event that an HAC or OPPC event occurs, institutional providers must submit a copy of the Member's record with the claim.

Charge Master Administration

Facility Providers are required to notify HPSJ of increases to its standard Charge Master prior to forty-five (45) days of implementation. Notification must be in writing and include detailed changes as well as overall percentage increases. Upon receipt of notification, HPSJ will make appropriate adjustments to reimbursement rates according to the terms outlined in the contract. In the event of an increase in the Facility's Charge Master, charge based reimbursement will be

adjusted according to the limits outlined in the Agreement, as follows:

Charge Master Limit / Charge Master Increases
X Current % of Charges
= New % of Charges Rate

Example

3% Charge Master Limit / 13% Actual Charge Master Increase
X 50% of Charge = 45.5%

(1.03 / 1.13) x 50.0% = 45.5% (New % of Charges Rate)

In the event of a Charge Master adjustment, HPSJ will amend the Facility's Agreement to reflect the new reimbursement rates for charge based services. The new reimbursement rates will become effective as of the effective date of the facility's Charge Master increase.

HPSJ will continuously monitor charge-based service charges and will have the right to audit the Charge Masters of contracted Facilities. Should HPSJ detect a significant change in the billed charges for charge-based services, HPSJ will contact the Facility in writing to request notification of changes that may not have been reported or to request an audit of the current Charge Master.

Late Notification of Charge Master Increase

In the event a Facility fails to provide forty-five (45) days prior notice of any change to the Charge Master, HPSJ will have the right to recalculate all payments made after the effective date of the Change Master change and recover overpayments resulting from the subsequent reduction in the percentage of charge-based reimbursement. HPSJ will provide notice to the Facility within one hundred twenty (120) days of becoming aware of Charge Master related overpayments and provide a detailed accounting of any overpaid amounts. If the facility fails to reimburse HPSJ within thirty (30) days of this notice, HPSJ may recover these amounts by offsetting subsequent payments.