

§ 1300.75.4. Definitions.

As used in these Solvency Regulations:

(a) "External party" means the Department of Managed Health Care or its designated agent, which may be contracted or appointed to fulfill the functions stated in these Solvency Regulations. Whenever these Solvency Regulations reference the Department of Managed Health Care ~~that reference means~~ it shall mean the Department of Managed Health Care (Department) or its designated agent.

(b) "Organization" means a risk-bearing organization as defined in Health and Safety Code Section 1375.4(g). An organization includes an entity that contracts directly with the plan or subcontracts with another organization to arrange for the health care services of a plan's enrollees and meets the requirements of Health and Safety Code section 1375.4(g).

(c) "Plan" means full-service health care service plan, as defined by Health and Safety Code section 1345(f).

(d) "Risk arrangement" is defined to include both "risk-sharing arrangement" and "risk-shifting arrangement," which are defined as follows:

(1) "Risk-sharing arrangement" means any compensation arrangement between an organization and a plan under which the organization shares the risk of financial gain or loss with the plan.

(2) "Risk-shifting arrangement" means a contractual arrangement between an organization and a plan under which the plan pays the organization on a fixed, periodic or capitated basis, and the financial risk for the cost of services provided pursuant to the contractual arrangement is assumed by the organization.

(e) "Solvency Regulations" means sections 1300.75.4 through 1300.75.4.8 of Title 28 of the California Code of Regulations.

(f) "Cash-to-claims ratio" is an organization's cash, readily available marketable securities and HMO capitation receivables due within thirty (30) days, excluding all-risk pool, risk-sharing, incentive payment program and pay-for-performance receivables, reasonably anticipated to be collected within 60 days divided by the organization's unpaid claims (claims payable and incurred but not reported [IBNR] claims) liability. The organization shall report only those HMO capitation receivables due within thirty (30) days the organization reasonably believes will be received by that time.

(g) "Corrective action plan" (CAP) means a plan reflected in a document containing requirements for correcting and monitoring an organization's efforts to correct any financial solvency deficiencies in the Grading Criteria or other financial or other claims payment deficiencies, determined through the Department's review or audit process, indicating that the organization may lack the capacity to meet its contractual obligations consistent with the requirements of section 1300.70(b)(2)(H)(1) of Title 28, California Code of Regulations.

(h) "Grading Criteria" means the four grading/reviewing criteria specified in Health and Safety Code sections 1375.4(b)(1)(A)(i), (ii), (iii), and (iv) and the cash-to-claims ratio as defined in subsection (f) above.

(i) "In a manner that does not adversely affect the integrity of the contract negotiation process" means the disclosure of an organization's financial data submissions in a format that does not impair the organization's ability to negotiate its contracts for the delivery of health care services or does not allow a contracting party to calculate: (1) an organization's precise profit/loss margins on any line of business, or (2) the rates that the organization has negotiated with any contracting entity or vendor during a prior accounting period.

(j) "Sponsoring organization" shall have the same meaning as Health and Safety Code section 1375.4(b)(1)(B).

(k) "Sub-delegating organization" means an organization that delegates any portion of the responsibility for providing or arranging for the health care services of a plan's enrollees to another organization on a capitated or fixed period payment basis.

Note: Authority cited; Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

§ 1300.75.4.1. Risk Arrangement Disclosure.

(a) Every contract involving a risk arrangement between a plan and an organization or between a sub-delegating organization and an organization shall require the plan or the sub-delegating organization to do all of the following:

(1) Disclose through electronic transmission (or in writing, if agreeable to both the organization and the plan or the sub-delegating organization) to the organization, on a monthly basis, ~~beginning with the month of May, 2001,~~ within ~~40~~ fifteen (15) calendar days of the beginning of each report month, the following information for each enrollee assigned to the organization: member identification number, name, birth date, gender, address (including zip code), plan contract selected, employer group identification, the identity of any other third party coverage, if known to the health plan, enrollment/disenrollment dates, medical group/IPA number, provider effective date, type of change to coverage, co-payment, deductible, the amount of capitation to be paid per enrollee per month, and the primary care physician when the selection of a primary care physician is required by the plan.

(2) Disclose through electronic transmission (or in writing, if agreeable to both the organization and the plan or the sub-delegating organization) to the organization, on a monthly basis, ~~beginning with the month of May, 2001,~~ within ~~40~~ fifteen (15) calendar days of the beginning of each report month, the names, member identification numbers, and total numbers of enrollees added or terminated under each benefit plan or sub-delegating organization contract served by the organization.

(3) If the information provided in paragraphs (1) and (2) is provided in more than one report, the plan or sub-delegating organization will ~~shall~~ disclose through electronic transmission (or in writing, if agreeable to both the organization and the plan or the sub-delegating organization) to the organization, on a quarterly basis, within ~~forty-five~~ (45) calendar days of the close of each quarter, a reconciliation of the variances between the information provided in paragraphs (1) and (2) above. ~~Beginning no later than January~~

~~4, 2002,~~ if the information in paragraphs (1) and (2) is provided in more than one report, all reports shall be processed as of the same date.

(4) ~~On or before October 1, 2001, and annually thereafter on~~ On the contract anniversary date, disclose to the organization, for the purpose of assisting the organization to be informed regarding the financial risk assumed under the contract, the following information for each and every type of risk arrangement (including, but not limited to, Medicare Advantage, Medicare+Choice, Medi-Cal, traditional commercial, Point of Service and commercial, including large group, small group, and individual plans) under the contract, including:

(A) a matrix of responsibility for medical expenses (physician, institutional, ancillary, and pharmacy) which will be allocated to the organization, facility, or the plan or the sub-delegating organization under the risk arrangement;

(B) expected/projected utilization rates and unit costs for each major expense service group (inpatient, outpatient, primary care physician, specialist, pharmacy, home health, durable medical equipment (DME), ambulance and other), the source of the data and the actuarial methods employed in determining the utilization rates and unit costs by benefit plan type for the type of risk arrangement; and

(C) all factors used to adjust payments or risk-sharing targets, including but not limited to the following: age, sex, localized geographic area, family size, experience rated, and benefit plan design, including copayment/deductible levels.

(5) ~~Beginning with the first quarter of calendar year 2001,~~ dDisclose through electronic transmission (or in writing, if agreeable to both the organization and the plan or the sub-delegating organization) to the organization, on a quarterly basis, within forty-five (45) calendar days of the close of each quarter, a detailed description of each and every amount (including expenses and income) that is sufficient to allow verification of the amounts allocated to the organization and to the plan or the sub-delegating organization under each and every risk-sharing arrangement. Where applicable, the following information, at a minimum, shall be provided:

~~1.~~ 1. (A) The total number of member months;

~~2.~~ 2. (B) the total budget allocation for the member months;

~~3.~~ 3. (C) the total expenses paid during the period;

~~4.~~ 4. (D) a description of the incurred but not reported (IBNR) claims methodology used for incurred expenses during the period; and

~~5.~~ 5. (E) a description of each and every amount of expense allocated to the risk arrangement by member identification number, date of service, description of service by claim codes, net payment and date of payment.

(6) For all risk-sharing arrangements, provide the organization with a preliminary payment report consistent with the requirements of paragraph (5) no later than one-hundred and fifty (150) days and payment no later than one-hundred and eighty (180) days after the close of the organization's contract year, or the contract termination date, whichever occurs first.

(b) In addition to the disclosures required by subsection (a) of this regulation, every contract involving a risk-sharing arrangement between a plan and an organization and, between a sub-delegating organization and an organization, shall require the plan or sub-delegating organization to disclose, ~~on or before October 1, 2001, and annually~~

thereafter on the contract anniversary date, the amount of payment for each and every service to be provided under the contract, including any fee schedules or other factors or units used in determining the fees for each and every service. To the extent that reimbursement is made pursuant to a specified fee schedule, the contract shall incorporate that fee schedule by reference, and further specify the Medicare RBRVS year if RBRVS is the methodology or if another model or methodology is used for fee schedule development. For any proprietary fee schedule, the contract ~~must~~shall include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.

(c) In addition to the disclosures required by subsection (a) of this regulation, every contract involving a risk-shifting arrangement between a plan and an organization or, between a sub-delegating organization and an organization, shall require the plan or the sub-delegating organization to disclose, ~~on or before October 1, 2001, and annually thereafter~~ on the contract anniversary date, in the case of capitated payment, the amount to be paid per enrollee per month, or the respective amount under a percentage of premium arrangement. For any deductions that the plan or sub-delegating organization may take from any capitation payment, the plan or sub-delegating organization shall provide details sufficient to allow the organization to verify the accuracy and appropriateness of the provided deduction ~~shall be provided~~.

Note: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

§ 1300.75.4.2. Organization Information.

Every contract involving a risk arrangement between a plan and an organization shall require the organization or sub-delegating organization to do the following:

(a) ~~Beginning January 1, 2006 maintain~~ Maintain at all times a minimum "cash-to-claims ratio," as defined in section 1300.75.4(f), of 0.60 0.75 except as specified below. Beginning October 1, 2019 and ending on October 1, 2020, an organization shall comply with the cash-to-claims ratio definition, which is defined as an organization's cash, readily available marketable securities and receivables, excluding all risk pool, risk-sharing, incentive payment program and pay-for-performance receivables, reasonably anticipated to be collected within sixty (60) days divided by the organization's unpaid claims (claims payable and incurred but not reported (IBNR) claims) liability. that shall be increased according to the following schedule:

- ~~(1) Beginning on July 1, 2006 the minimum cash-to-claims ratio shall be 0.65; and~~
- ~~(2) Beginning on January 1, 2007 and thereafter the minimum cash-to-claims ratio shall be 0.75.~~

(b) DMHC Quarterly Financial Survey Report Form ("quarterly financial survey report"). For each quarter, ~~beginning on or after July 1, 2005~~ submit to the Department, not more than forty-five (45) days after the close of each quarter of the fiscal year, a quarterly financial survey report on the DMHC Quarterly Financial Survey Report Form, dated September, 2018, as incorporated herein by reference, and published by the Department on its webpage: www.dmhc.ca.gov. The DMHC Quarterly Financial Survey Report Form shall be filed in an electronic format to be supplied by the Department of

~~Managed Health Care (Department)~~ pursuant to section 1300.41.8 of Title 28, California Code of Regulations, and shall contain~~containing~~ all of the following information:

~~(1) For organizations serving at least 10,000 covered lives under all risk arrangements as of December 31 of the preceding calendar year:~~

~~(1)(A) Quarterly F~~financial survey report information (including the following: a balance sheet; an income statement; and a statement of cash flows; a statement of net worth; cash and cash equivalent; receivables and payables; risk pool and other incentives; claims aging; notes to financial statements; enrollment information; mergers, acquisitions and discontinued operations; the incurred but not reported (IBNR) methodology; and administrative expenses), or in the case of a nonprofit entity comparable financial statements and supporting schedule information (including but not limited to, aging of receivable information), reflecting the results of operations for the immediately preceding quarter and year-to-date, prepared in accordance with generally accepted accounting principles (GAAP) and the identification of the individual or office in the organization designated to receive public inquiries.

~~(A) Sub-delegating organizations shall list all contracting organizations, including their names, addresses, contact persons, telephone numbers, and number of enrollees assigned to the organization as of the last day of the quarter being reported.~~

~~(B) Quarterly F~~Quarterly Ffinancial survey reports of an organization required pursuant to these rules shall be on a combining basis with an affiliate, if either the organization or such affiliate is legally or financially responsible for the payment of the organization's claims. Any affiliated entity included in this report shall be separately identified and reported in a combining schedule format. Upon the request of the Director, the organization or affiliate subject to this subdivision shall provide financial statements on a separate DMHC Quarterly Financial Survey Report Form. The Director shall consider at least the following information when determining whether to make the request:

(i) Whether financial solvency concerns exist with the organization or the affiliate, which impact the organization's ability to maintain compliance with the Grading Criteria or processing and paying claims in compliance with Claims Settlement Practices as detailed in section 1300.71 of Title 28, California Code of Regulations;

(ii) Whether there are concerns regarding the transparency of the affiliate relationship; and,

(iii) Whether financial documentation is not presented in accordance with GAAP.

~~(C) For the purposes of this section, an organization's use:~~

~~1. (i) Of a "sponsoring organization" arrangement to reduce its liabilities for the purposes of calculating tangible net equity, and working capital, and cash-to-claims ratio; or~~

~~2. (ii) An affiliated entity to provide claims processing services shall not be construed to automatically create a legal or financial obligation to pay the claims liability for the health care services for enrollees.~~

~~(2)(B) A statement as to what percentage of completed claims the organization has timely reimbursed, contested, or denied during the quarter in accordance with the requirements of Health and Safety Code sections 1371, and 1371.35, section 1300.71 of Title 28 of the California Code of Regulations, and any other applicable state and federal laws and regulations. If less than 95% of all complete claims have been reimbursed, contested or denied on a timely basis, the statement shall be accompanied~~

by a report that describes the reasons why the claims adjudication process is not meeting the requirements of applicable law, any action taken to correct the deficiency, and any results of that action. This claims payment report is for the purpose of monitoring the financial solvency of the organization and is not intended to change or alter existing state and federal laws and regulations relating to claims payment settlement practices and timeliness.

~~(3)(C)~~ A statement as to whether or not:

~~1. (A) The organization has estimated and documented, on a monthly basis, its liability for IBNR claims, pursuant to a method specified in section 1300.77.2; and~~

~~2. (B) The estimates are the basis for the quarterly financial survey report submitted under these Solvency Regulations. If the estimated and documented liability has not met the requirements of section 1300.77.2 in any way, a statement shall be included in the quarterly financial survey report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, the action taken to correct the deficiency, and the results of that action. An organization failing:~~
~~(i)a. To estimate and document, on a monthly basis, its liability for IBNR claims; or~~
~~(ii)b. To maintain its books and records on an accrual accounting basis shall be deemed to have failed to maintain, at all times, positive tangible net equity (TNE) and positive working capital as set forth in subsection (4D) below.~~

~~(4)(D)1. A statement as to whether or not the organization has at all times during the quarter maintained positive TNE, as defined in section 1300.76(c)(e) of Title 28 California Code of Regulations; and has at all times during the quarter maintained positive working capital, calculated in a manner consistent with GAAP, that excludes unsecured affiliate receivables except those arising in the normal course of business which are payable on the same terms as equivalent transactions with non-affiliates. If either the required TNE, cash-to-claims ratio, or the required working capital has not been maintained at all times, a statement shall be included in the quarterly financial survey report that describes in detail the following, with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.~~

~~(A)2. The organization may reduce its liabilities or increase its cash for purposes of calculating its TNE, working capital and cash-to-claims ratio in a manner allowed by Health and Safety Code section 1375.4(b)(1)(B) and this section so long as the sponsoring organization has filed with the Department:~~

~~(i)a. Its audited annual financial statements within one-hundred and twenty (120) days of the end of the sponsoring organization's fiscal year; and~~

~~(ii)b. A copy of the written guarantee meeting the requirements of Health and Safety Code section 1375.4(b)(1)(B). For purposes of Health and Safety Code section 1375.4(b)(1)(B), a sponsoring organization shall have a TNE of at least twice the total of all amounts that it has guaranteed to all persons and entities, or a lesser amount in situations where the organization can demonstrate to the Director's satisfaction and written approval that a lesser amount of TNE is sufficient. If an organization has a sponsoring organization, the organization shall provide information to the Department demonstrating the capacity of the sponsoring organization to guarantee the organization's debts, as well as the nature and scope of the guarantee provided, consistent with Health and Safety Code section 1375.4(b)(1)(B).~~

a. An organization may rely on a sponsoring organization for no more than one (1) fiscal year to reduce the organization's liabilities or increase its cash for purposes of calculating its TNE, working capital and cash-to-claims ratio. Requests by an organization to extend the one (1) year period and to rely on a sponsoring organization during a subsequent period shall be submitted to the Department and may be approved at the Director's discretion. Only a single twelve (12) month extension of the use of a sponsoring organization may be requested by the organization. The Director shall consider at least the following information when determining whether to grant the request:

1. Financial projections demonstrating the compliance timeframes outlined by the organization;

2. Specific actions taken and proposed by the organization to improve financial solvency; and,

3. Any modifications or changes to the guarantee provided by the sponsoring organization.

b. An organization shall apply to the Department to request the use of a sponsoring organization. The application shall include projections showing how the organization will obtain and maintain compliance with requirements of Health and Safety Code section 1375.4(b)(1)(A) once the guarantee from the sponsoring organization terminates.

c. If the period that an organization has a sponsoring organization is longer than twelve (12) months, the organization shall annually, from the date of the sponsoring organization contract, report to the Department projections showing how the organization will obtain and maintain compliance with the requirements of Health and Safety Code section 1375.4(b)(1)(A) once the guarantee from the sponsoring organization terminates.

~~(5)(E) For the quarter beginning on or after January 1, 2006, a A statement as to whether or not the organization has, at all times during the quarter, maintained a cash-to-claims ratio as required in section (a), calculated in a manner consistent with GAAP. If the required cash-to-claims ratio has not been maintained at all times, a statement shall be included in the quarterly financial survey report that describes in detail the following with respect to the deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.~~

~~(2) For organizations serving less than 10,000 covered lives under all risk arrangements as of December 31 of the preceding calendar year:~~

~~(A) The disclosure statement(s) set forth in sections (b)(1)(B), (C), (D) and (E) above.~~

~~(B) In the event an organization serving less than 10,000 covered lives under all risk arrangements: 1. fails to satisfactorily demonstrate its compliance with the Grading Criteria; 2. experiences an event that materially alters the organization's ability to remain compliant with the Grading Criteria; 3. is found, by the external party's review or audit activities, to potentially lack sufficient financial capacity to continue to accept financial risk for the delivery of health care services consistent with the requirements of section 1300.70(b)(2)(H)(1); or 4. is found, through the Department's HMO Help Center, medical audits and surveys, or any other source, to be delaying referrals, authorizations, or access to basic health care services based on financial considerations, the organization shall, within 30 calendar days of the Department's~~

~~written request, begin submitting complete quarterly financial survey reports pursuant to section 1300.75.4.2(b)(1):~~

(c) DMHC Annual Financial Survey Report Form ("annual financial survey report").

~~(1) Regardless of the number of covered lives served under all risk arrangements, An organization shall submit to the Department, not more than one hundred fifty (150) days after the close of the organization's fiscal year beginning on or after January 1, 2005, and not more than one hundred fifty (150) days after the close of each of the organization's subsequent fiscal years, an annual financial survey report on the DMHC Annual Financial Survey Report Form, dated September 2018, as incorporated herein by reference and published by the Department on its webpage: www.dmhc.ca.gov. The DMHC Annual Financial Survey Report Form shall be filed in an electronic format to be supplied by the Department pursuant to section 1300.41.8 of Title 28 of the California Code of Regulations, and shall be based upon the organization's annual audited financial statement prepared in accordance with generally accepted accounting auditing standards, principles (GAAP). The annual financial survey report shall contain and containing all of the following:~~

~~(1)(2) Annual financial survey report, based upon the organization's annual audited financial statements (including at least the following: a balance sheet; an income statement; a statement of cash flows; a statement of net worth; cash and cash equivalent; receivables and payables; risk pool and other incentives; claims aging; notes to financial statements; enrollment information; mergers, acquisitions and discontinued operations; the incurred but not reported (IBNR) methodology; administrative expenses; and, footnote disclosures), or in the case of a nonprofit entity, comparable financial statements, and supporting schedule information, (including, but not limited, to, aging of receivable information and debt maturity information), for the immediately preceding fiscal year, prepared by the independent certified public accountant in accordance with GAAP.~~

~~(A) A sub-delegating organization shall include the allocation of risk between the sub-delegating organization and each organization with which it contracts and shall disclose whether the sub-delegating organization provides stop-loss coverage to the organization, and if so, the nature of all stop-loss arrangements.~~

~~(B)(3) FAnnual financial survey reports of an organization required pursuant to these Solvency Regulations shall be on a combining basis with an affiliate if either the organization or such affiliate is legally or financially responsible for the payment of the organization's claims. Any affiliated entity included in the report shall be separately identified. Upon the request of the Director, the organization or affiliate subject to this subdivision shall provide financial statements on a separate DMHC Annual Financial Survey Report Form. The Director shall consider at least the following information when determining whether to make the request:~~

~~(i) Whether financial solvency concerns exist with the organization or the affiliate, which impact the organization's ability to maintain compliance with the Grading Criteria or processing and paying claims in compliance with Claims Settlement Practices as detailed in section 1300.71 of Title 28, California Code of Regulations;~~

~~(ii) Whether there are concerns regarding the transparency of the affiliate relationship; and,~~

~~(iii) Whether financial documentation is not presented in accordance with GAAP.~~

(C) For the purposes of this section, an organization's use of:

~~(i)(A)~~ A "sponsoring organization" arrangement to reduce its liabilities for the purposes of calculating TNE and working capital, cash-to-claims ratio; or

~~(ii)(B)~~ An affiliated entity to provide claims processing services shall not be construed to automatically create a legal or financial obligation to pay claims liability for health care services for enrollees.

~~(D)1.~~ When combined financial statements are required by this regulation, the independent accountant's report or opinion ~~shall~~ must address all the entities included in the combined financial statements. If the accountant's report or opinion makes reference to the fact that another auditor performed a part of the examination, the organization shall also file the report or opinion issued by the other auditor.

~~(i)2.~~ For purposes of determining the independence of the certified public accountant, the regulations of the California State Board of Accountancy (Division 1, sections 1 through 99.2, Title 16, California Code of Regulations), shall apply.

~~(E)(4)~~ The opinion of the independent certified public accountant indicating: ~~(A)~~ whether the organization's annual audited financial statements present fairly, in all material respects, the financial position of the organization, and whether the financial statements were prepared in accordance with GAAP. If the opinion is qualified in any way, the survey report shall include an explanation regarding the nature of the qualification.

~~(2)(5)~~ A statement as to whether or not the organization has estimated and documented, on a monthly basis, its liability for IBNR claims, pursuant to a method specified in section 1300.77.2, and that these estimates are the basis for the financial survey reports submitted under these Solvency Regulations. If the estimated and documented liability has not met the requirements of section 1300.77.2, a statement shall be included in the annual financial survey report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, the action taken to correct the deficiency, and the results of that action. An organization failing:

(A) ~~T~~to estimate and document, on a monthly basis, its liability for IBNR claims; or

(B) ~~T~~to maintain its books and records on an accrual accounting basis, shall be deemed to have failed to maintain, at all times, positive TNE and positive working capital as set forth in subsection ~~(3)(6)(A)~~ below.

~~(3)(6)(A)~~ A statement as to whether or not the organization has, at all times during the year, maintained positive TNE, as defined in section 1300.76~~(c)(e)~~ of Title 28, California Code of Regulations; and has, at all times during the year, maintained positive working capital, calculated in a manner consistent with GAAP, that excludes unsecured affiliate receivables except those arising in the normal course of business which are payable on the same terms as equivalent transactions with non-affiliates. If either the required TNE, cash-to-claims ratio, or the required working capital has not been maintained at all times, a statement shall be included in the annual financial survey report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

~~(A)(B)~~ The organization may reduce its liabilities for purposes of calculating its TNE and working capital in a manner allowed by Health and Safety Code section 1375.4(b)(1)(B) and this section, so long as the sponsoring organization has filed, with the Department:

4. (i) Its audited annual financial statements within one-hundred and twenty (120) days of the end of the sponsoring organization's fiscal year and

2. (ii) a A copy of the written guarantee meeting the requirements of Health and Safety Code section 1375.4(b)(1)(B). For purposes of Health and Safety Code section 1375.4(b)(1)(B), a sponsoring organization shall have a TNE of at least twice the total of all amounts that it has guaranteed to all persons and entities, or a lesser amount in situations where the organization can demonstrate to the Director's satisfaction and written approval that a lesser amount of TNE is sufficient. If an organization has a sponsoring organization, the organization shall provide information to the Department demonstrating the capacity of the sponsoring organization to guarantee the organization's debts as well as the nature and scope of the guarantee provided consistent with Health and Safety Code section 1375.4(b)(1)(B).

a. An organization may rely on a sponsoring organization for no more than one (1) fiscal year to reduce the organization's liabilities or increase its cash for purposes of calculating its TNE, working capital and cash-to-claims ratio. Requests by an organization to extend the one (1) year period and to rely on a sponsoring organization during a subsequent period shall be submitted to the Department and may be approved at the Director's discretion. Only a single twelve (12) month extension of the use of a sponsoring organization may be requested by the organization. The Director shall consider at least the following information when determining whether to grant the request:

1. Financial projections demonstrating the compliance timeframes outlined by the organization;
2. Specific actions taken and proposed by the organization to improve financial solvency; and,
3. Any modifications or changes to the guarantee provided by the sponsoring organization.

b. An organization shall apply to the Department to request the use of a sponsoring organization. The application shall include projections showing how the organization will obtain and maintain compliance with the requirements of Health and Safety Code section 1375.4(b)(1)(A) once the guarantee from the sponsoring organization terminates.

c. If the period that an organization has a sponsoring organization is longer than twelve (12) months, the organization shall annually, from the date of the sponsoring organization contract, report to the Department projections showing how the organization will obtain and maintain compliance with the requirements of Health and Safety Code section 1375.4(b)(1)(A) once the guarantee from the sponsoring organization terminates.

(4)(7) For the fiscal year beginning on or after January 1, 2006, aA statement as to whether or not the organization has at all times during the year maintained a cash-to-claims ratio as required in section (a), calculated in a manner consistent with GAAP. If the required cash-to-claims ratio has not been maintained at all times, a statement shall be included in the quarterly financial survey report that describes in detail the following with respect to the deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

~~(5)~~(8) A statement as to whether the organization maintains reinsurance and/or professional stop-loss coverage.

~~(6)~~(9) The annual financial survey report shall include, as an attachment, a copy of the complete annual audited financial statement, including footnotes and the certificate or opinion of the independent certified public accountant.

(d) Statement of Organization Survey. Submit to the external party, a "Statement of Organization," in an electronic format, prepared by the Department, to be filed along with the annual financial survey report, which shall include the following information, as of December 31 of each calendar year prior to the filing:

(1) Name and address of the organization;

(2) A financial and public contact person, with title, address, telephone number, fax number, and e-mail address;

(3) A list of all health plans with which the organization maintains risk arrangements;

(4) Whether the organization is an Independent Practice Association (IPA), Medical Group, Foundation, other entity, or some combination thereof. If the organization is a foundation, identify each and every medical group within the foundation, and whether any of those medical groups independently qualifies as a risk-bearing organization as defined in Health and Safety Code section 1375.4(g);

(5) Whether the organization is a professional corporation, partnership, not-for-profit corporation, sole proprietor, or other form of business;

(6) The name, business address and principal officer of each of the organization's affiliates as defined in Title 28, California Code of Regulations, section 1300.45(c)(1) and (2);

(7) Whether the organization is partially or wholly owned by a hospital or hospital system;

(8) A matrix listing all major categories of medical care offered by the organization, including, but not limited to, anesthesiology, cardiology, orthopedics, ophthalmology, oncology, obstetrics/gynecology and radiology.

(A) Next to each listed category in the matrix, a disclosure of the primary compensation model (salary, fee-for-service, capitation, other) used by the organization to compensate the majority of providers of that category of care;

(9) An approximation of the number of enrollees served by the organization under a risk arrangement, pursuant to a list of ranges developed by the Department;

(10) Any Management Services Organization (MSO) that the organization contracts with for administrative services;

(11) The total number of contracted physicians in employment and/or contractual arrangements with the organization;

(12) Disclosure of the organization's primary service area (excluding out-of-area tertiary facilities and providers) by California county or counties;

(13) The identification of the organization's address, telephone number and website link, if available, where providers may access written information and instructions for filing of provider disputes with the organization's Dispute Resolution Mechanism consistent with requirements of section 1300.71.38 of Title 28, California Code of Regulations; and,

(14) Provide any other information that the Director deems reasonable and necessary, as permitted by law, to understand the operational structure and finances of the organization.

(e) Submit a written verification for each report made under subsections (b), (c), and (d) of this section stating that the report is true and correct to the best knowledge and belief of a principal officer of the organization, and, if the report is a combined report, a principal officer of the affiliate, and signed by both a principal officers, as defined by section 1300.45(o) of Title 28, California Code of Regulations. This verification shall be submitted by delivering a hard copy with an original signature to the Director, care of the Office of Financial Review, Department of Managed Health Care, 980 Ninth Street, Suite 500, Sacramento, CA 95814.

(f) Notify the Department and each contracting health plan or sub-delegating organization no later than five (5) business days after discovering that the organization has experienced any event that materially alters its financial situation or threatens its solvency. Each sub-delegating organization shall have adequate procedures in place to ensure the Department of Managed Health Care or its designated agent is notified no later than five (5) business days from discovering that any of its contracting organizations experienced any event which materially alters the organization's financial situation, or threatens its solvency.

(g) Permit the Department to make any examination that it deems reasonable and necessary to implement Health and Safety Code section 1375.4, and provide to the Department, upon request, any books or records deemed relevant or useful to implementing this section for inspection and copying, as permitted by law.

Note: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

§ 1300.75.4.5. Plan and Sub-Delegating Organization Compliance.

(a) Every plan and sub-delegating organization that maintains a risk arrangement with an organization shall have adequate procedures in place to ensure:

(1) That plan or sub-delegating organization personnel review all reports and financial information made available pursuant to Health and Safety Code section 1375.4, and these Solvency Regulations, and as provided under the terms of the contract with an organization as part of the plan's responsibility to evaluate and ensure the financial viability of its arrangements consistent with section 1300.70(b)(2)(H)(1) of Title 28, California Code of Regulations;

(2) ~~That a~~Appropriate action(s) are taken following the Department's written notification to an organization's contracting health plan(s) or sub-delegating organization(s) that the organization has:

(A) ~~The organization has failed~~ Failed to substantially comply with the reporting obligations specified in section 1300.75.4.2 of Title 28, California Code of Regulations, by failing to file a required periodic financial and organizational information disclosure, including the filing of an annual financial survey report based upon an audited financial statement prepared in accordance with generally accepted accounting principles (GAAP), or by failing to include significant portions of information on a required periodic financial organizational information disclosure;

~~(B) The organization has refused~~ Refused to permit the activities of the Department as specified in Health and Safety Code section 1375.4 or in these Solvency Regulations;
or,

~~(C) The organization has failed~~ Failed to substantially comply with the requirements of a final CAP for a period of more than ninety (90) days, as determined by the Department.

(3) Appropriate action shall include, but is not limited to, a prohibition on the assignment or addition of any additional enrollees to the risk arrangement with that organization without the prior written approval of the Director. The prohibition on assignments of additional enrollees to an organization pursuant to subsection (2) shall not apply to dependents of enrollees who are already under the risk-arrangement with the organization or to enrollees who selected the organization during an open enrollment or other selection period that was prior to the effective date of the prohibition on the assignment of additional enrollees. The prohibition on the assignment of additional enrollees shall take effect thirty (30) days after the date of Department's notification to the organization's contracting plan(s), and shall remain in effect until the Department notifies the organization's contracting health plan in writing that the organization's non-compliance has been remedied.

~~(4) That~~ The plan or sub-delegating organization complies with the corrective action process and cooperates in the implementation of a final CAP, as defined in section 1300.75.4.8, including, but not limited to, implementing contingency plans for continuous delivery of health care services to plan enrollees served by the organization.

~~(5) That~~ The plan or sub-delegating organization shall advise the Department and the organization in writing within five (5) days of becoming aware:

~~(1)(A)~~ that a contracting organization is not in compliance with the requirements of a final CAP, or

~~(2)(B)~~ that an organization's conduct may cause the plan to be subject to disciplinary action pursuant to Health and Safety Code section 1386.

~~(6) That~~ if a plan proposes to transfer plan enrollees receiving care from an organization that is compliant with a final CAP to alternative providers and the reassignment is based, in part, on the organization's failure to meet one or more of the Grading Criteria, the plan shall, prior to transferring enrollees from that organization, file with the Department a Block Transfer Filing pursuant to Health and Safety Code section 1373.65. In addition to all other criteria for reviewing block transfers, the Director may disapprove, postpone or suspend the plan's proposed transfer of enrollees if the department reasonably determines:

(A) That the proposed reassignment of enrollees will likely cause the organization's failure or result in the organization ceasing operations within three (3) months;

(B) That the organization has the financial and administrative capacity to provide timely access to care through an adequate network of qualified health care providers; and

(C) That the organization is not denying or delaying basic health care services or continuity of care for the plan's enrollees assigned to the organization.

(7) If a sub-delegating organization proposes to transfer plan enrollees receiving care from an organization that is compliant with a final CAP to alternative providers and the reassignment is based, in part, on the organization's failure to meet one (1) or more of the Grading Criteria, the sub-delegating organization shall notify the plan, prior to

transferring enrollees from the organization, and the plan shall determine whether it is necessary to file with the Department a Block Transfer Filing pursuant to Health and Safety Code section 1373.65. In addition to all other criteria for reviewing block transfers, the Director may disapprove, postpone or suspend the sub-delegating organization's proposed transfer of enrollees if the Department reasonably determines:

(A) That the proposed reassignment of enrollees will likely cause the organization's failure or result in the organization ceasing operations within three (3) months;

(B) That the organization has the financial and administrative capacity to provide timely access to care through an adequate network of qualified health care providers; and

(C) That the organization is not denying or delaying basic health care services or continuity of care for the plan's enrollees assigned to the organization.

(78) Notwithstanding subsection (6) and (7) of this section, nothing in these regulations shall limit or impair:

(1)(A) the Director's authority, consistent with Health and Safety Code sections 1367, 1373.65-(b) and 1391.5, to require a plan to reassign or transfer plan enrollees to alternate providers or organizations on an expedited basis to avoid imminent harm to enrollees;

(2)(B) an enrollee's right to self-select a new provider; or

(3)(C) the plan's ability to transfer individual enrollees assigned to a provider who terminates his/her relationship with the organization to ensure that the enrollee receives appropriate continuity of care.

(b) Every contract involving a risk arrangement between a plan and an organization and every contract involving a risk arrangement between a sub-delegating organization and an organization, shall provide that an organization's failure to substantially comply with the contractual requirements required by these Solvency Regulations shall constitute a material breach of the risk arrangement contract. A Neither a plan nor sub-delegating organization shall not request or accept a waiver of any the contractual requirements set forth in these Solvency Regulations.

(c) Within thirty (30) days of notification pursuant to section 1300.75.4.5(a)(2)(C) of Title 28, California Code of Regulations, a plan or sub-delegating organization shall submit to the Department a specific Provider Transition Plan for the deficient organization which provides for the continuity of care for plan enrollees served by the organization.

(d) Any failure of a plan to comply with the requirements of Health and Safety Code section 1375.4 and these Solvency Regulations shall constitute grounds for disciplinary action against the plan pursuant to Health and Safety Code section 1386.

(e) The Director may seek and employ any combination of remedies and enforcement procedures provided under the Knox-Keene Act to enforce Health and Safety Code section 1375.4 and these Solvency Regulations.

Note: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

§ 1300.75.4.7. Organization Evaluation.

(a) Every contract involving a risk arrangement between a plan and an organization or a sub-delegating organization and an organization shall:

(1)(a) Require the organization to comply with the Department of Managed Health Care's review and audit process, in determining the organization's satisfaction of the Grading Criteria; and

(2)(b) Permit the Department to perform any of the following activities in conjunction with the plan's oversight process:

(A)(1) Obtain and evaluate supplemental financial information pertaining to the organization when:

1.(A) the organization fails to satisfactorily demonstrate its compliance with the Grading Criteria;

2.(B) the organization experiences an event that materially alters its ability to remain compliant with the Grading Criteria;

3.(C) the external party's review or audit process indicates that the organization may have insufficient financial capacity to continue to accept financial risk for the delivery of health care services consistent with the requirements of sections 1300.70(b)(2)(H)(1) of Title 28, California Code of Regulations; or

4.(D) the Department receives information from complaints submitted to the HMO Help Center, health plan reporting, medical audits and surveys or any other source that indicates the organization may be delaying referrals or authorizations or failing to meet access standards for basic health care services based on financial considerations.

Note: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

§ 1300.75.4.8. Corrective Action.

Every contract involving a risk arrangement between a plan and an organization or a sub-delegating organization and an organization shall require the plan and the organization or the sub-delegating organization and the organization to comply with a process, set forth in this regulation and administered by the Department, for the development and implementation of Corrective Action Plans (CAPs).

(a) Organizations reporting deficiencies in any of the Grading Criteria shall submit a self-initiated CAP proposal on the DMHC Corrective Action Plan (CAP) Form, dated May, 2018, and incorporated by reference herein, published by the Department on its webpage at www.dmhc.ca.gov to the Department and to every plan and sub-delegating organization with which the organization maintains a contract involving a risk arrangement that meets the following requirements:

(a) Unless the organization has proactively demonstrated to the Department's written satisfaction that necessary and prudent capital investments has or may cause a temporary deficiency in its TNE, working capital or cash-to-claims ratios and that it has implemented an appropriate business plan that will correct the deficiency within a reasonable time period without causing a deficiency in its claim payment timeliness, beginning with the financial survey submission filed for the third quarter of calendar year 2005, organizations reporting deficiencies in any of the Grading Criteria shall

~~simultaneously submit a self-initiated CAP proposal, in an electronic format developed by the Department, to the Department and every plan with which the organization maintains a contract involving a risk arrangement that meets the following requirements:~~

- ~~(1) Identifies the Grading Criteria that the organization has failed to meet;~~
- ~~(2) Identifies the amount by which the organization has failed to meet the Grading Criteria;~~
- ~~(3) Identifies all plans and sub-delegating organizations with which the organization has contracts with involving a risk arrangement, including the identification of the name, title, telephone and facsimile numbers, and postal and e-mail addresses for the person responsible at each contracting health plan and sub-delegating organization for monitoring compliance with the final CAP;~~
- ~~(4) Describes the specific actions the organization has taken or will take to correct any deficiency identified in subsections (1) and (2) of this section. This description should include any written representations made by contracting health plans and sub-delegating organizations to assist the organization in the implementation of its CAP. The actions shall be appropriate and reasonable in scope and breadth depending upon the nature and degree of the deficiency, and acceptable to the Department;~~
- ~~(5) Describes the timeframe for completing the corrective action and specifies a schedule for submitting progress reports to the Department and the organization's contracting health plans and sub-delegating organizations. Except in situations where the organization can demonstrate to the Department's satisfaction and written approval that an extended period of time is necessary and appropriate to correct the deficiency, that:
 - ~~(A) Timetables specified in the self-initiated CAP for correcting working capital deficiencies shall not exceed twelve (12) months;~~
 - ~~(B) Timetables specified in the self-initiated CAP for correcting tangible net equity (TNE) deficiencies shall not exceed twelve (12) months;~~
 - ~~(C) Timetables specified in the self-initiated CAP for incurred but not reported (IBNR) deficiencies shall not exceed three (3) months;~~
 - ~~(D) Timetables specified in the self-initiated CAP for correcting claims timeliness deficiencies shall not exceed six (6) months;~~
 - ~~(E) Timetables specified in the self-initiated CAP for correcting cash-to-claims ratio deficiencies shall not exceed twelve (12) months.~~~~
- ~~(6) Identifies the name, title, telephone and facsimile numbers, and postal and e-mail addresses for the person responsible at the organization for ensuring compliance with the final CAP; and~~
- ~~(7) Describe:
 - ~~(A) the organization's patient record retention and storage policies;~~
 - ~~(B) the procedures and the steps the organization will take to ensure that patient medical records are appropriately stored and maintained; and~~
 - ~~(C) the procedures and the steps the organization will take to ensure that patient medical records will be readily available and transferable to patients in the event the organization ceases operations or the organization fails to meet its obligations set forth in the final CAP. At a minimum, an organization's patient medical records policies and procedures shall be consistent with existing laws relating to the responsibilities for the~~~~

~~preservation and maintenance of medical records and the protection of the confidentiality of medical information.~~

(7) An organization may avoid submitting a self-initiated CAP proposal if it demonstrates to the Department that necessary and prudent capital investments have caused or may cause a temporary deficiency in its TNE, working capital, or cash-to-claims ratios and that the organization has implemented an appropriate business plan that will correct the deficiency within a reasonable time period without causing a deficiency in the organization's claims processing timeliness. The organization shall seek and receive written approval from the Department to avoid submitting a self-initiated CAP proposal.

(b) To the extent possible, the self-initiated CAP proposal shall be set forth in a single document that addresses the concerns of all plans and sub-delegating organizations with which the organization maintains a contract that includes a risk arrangement.

(c) Unless, within fifteen (15) calendar days of the receipt of an organization's self-initiated CAP proposal, a contracting health plan or sub-delegating organization provides written notice to the Department and the risk-bearing organization stating the reason for its objections and recommendations for revisions, the self-initiated CAP shall be considered a final CAP subject to approval by the Department, subject to the Department's approval process as set forth in sections (g) and (h) below.

(d) In the event that a contracting health plan or sub-delegating organization files a written objection with the Department and the risk-bearing organization, the organization Department shall, within twenty (20) ten (10) calendar days, (1) review the objections and inform the organization if revisions to the CAP proposal are needed or if the objections can be resolved. If the objections can be resolved, the self-initiated CAP proposal shall be considered the final CAP subject to approval by the Department. If revisions to the CAP proposal are required, the organization will have ten (10) calendar days to:

(1) implement Implement all corrective action strategies contained in its self-initiated CAP proposal that were not objected to by a contracting health plan; and

(2) submit Submit to each of its contracting health-plans and sub-delegating organizations and the Department a revised CAP proposal that addresses the concerns raised by the objecting contracting health plan(s) in the objections. To the extent possible, the revised CAP proposal shall be prepared as a single document that addresses the concerns of all plans and sub-delegating organizations with which the organization maintains a contract that includes a risk arrangement.

(e) Each contracting health-plan and sub-delegating organization shall have ten (10) seven (7) calendar days to either accept or object to the self-initiated revised CAP proposal. If a plan or sub-delegating organization objects to the revised CAP proposal, the objection(s) and recommended revisions shall be submitted submit to the organization and the Department its objections and recommended revisions, in an electronic format prepared by the Department, to the self-initiated revised CAP proposal. If there are no objections, the self-initiated revised CAP proposal shall become the final CAP subject to approval by the Department.

(f) Within fifteen (15) seven (7) calendar days of receipt of any contracting health-plans' or sub-delegating organization's objections and recommended revisions to the revised CAP proposal, the Department shall schedule a meeting ("CAP Settlement

Conference") with the organization and all of its contracting health plans and sub-delegating organizations to discuss and reconcile the differences.

(g) Within seven (7) calendar days of the CAP Settlement Conference, the organization shall submit a final self-initiated CAP proposal to all of its contracting health-plans, sub-delegating organizations, and the Department.

(h) Within ~~ten (10)~~ twenty (20) calendar days of receipt of the organization's final self-initiated CAP proposal, the external party shall submit its recommendation to the Department to approve, disapprove or modify the organization's final self-initiated CAP proposal.

(i) Within ~~ten (10)~~ seven (7) calendar days of receipt of the external party's recommendation, the Department shall approve, disapprove or modify the organization's final self-initiated CAP proposal, which shall then become the final CAP. If the Department does not act upon the recommendations of the external party within ~~ten (10)~~ seven (7) calendar days, the external party's recommendation shall be deemed approved.

(j) A final CAP shall remain in effect until the organization demonstrates compliance with the requirements of the CAP, or the CAP expires in accordance with its own terms.

(k) In addition to the CAP requirements specified in subsection (a) above, the Department may direct an organization to initiate a CAP whenever it determines that an organization has experienced an event that materially alters its ability to remain compliant with the Grading Criteria or when the Department's review process indicates that the organization may lack sufficient financial capacity to meet its contractual obligations consistent with the requirements of section 1300.70(b)(2)(~~H44~~)(4) of Title 28, ~~of the~~ California Code of Regulations.

(l) CAP Reporting:

(1) Each periodic progress report prepared pursuant to a final CAP shall be submitted to the Department and all plans and sub-delegating organizations with which the organization has a contract involving a risk arrangement, and shall include a written verification stating that the periodic progress report is true and correct to the best knowledge and belief of a principal officer of the organization, as defined by section 1300.45(o) of Title 28 California Code of Regulations.

(2) In addition to the quarterly progress reports specified in a CAP, every contract involving a risk arrangement between a plan or sub-delegating organization and an organization shall require that:

(A) the organization advise the plan and the Department in writing within five (5) calendar days if the organization experiences an event that materially alters the organization's ability to remain compliant with the requirements of a final CAP; and
(B) the organization, upon the Department's request, provides additional documentation to the Department and its contracting plans to demonstrate the organization's progress towards fulfilling the requirements of a CAP.

(3) Non-disclosure of CAP documentation and supporting work papers:

(A) All draft, preliminary and final CAPs and all CAP compliance reports required by a final CAP, including supporting documentation and supplemental financial information, submitted to the Department shall be received and maintained on a confidential basis and shall not be disclosed, except for the information outlined in section

1300.75.4.4(c)(3) to any party other than the organization and, as necessary, to its contracting health plans and sub-delegating organizations that are participating in the CAP.

Note: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

§ 1300.76. Plan Tangible Net Equity Requirement.

(a) Except as provided in subsection (b), each plan licensed pursuant to the provisions of the Act shall, at all times, have and maintain a tangible net equity at least equal to the greater of:

(1) \$1 million; or

(2) the sum of two percent (2%) of the first \$150 million of annualized premium revenues plus one percent (1%) of annualized premium revenues in excess of \$150 million; or

(3) an amount equal to the sum of:

(A) eight percent (8%) of the first \$150 million of annualized health care expenditures except those paid on a capitated basis or managed hospital payment basis; plus

(B) four percent (4%) of the annualized health care expenditures, except those paid on a capitated basis or managed hospital payment basis, which are in excess of \$150 million; plus

(C) four percent (4%) of annualized hospital expenditures paid on a managed hospital payment basis.

(b) Each plan licensed pursuant to the provisions of the Knox-Keene Act and which offers only ~~only offers~~ specialized health care service contracts shall, at all times, have and maintain a tangible net equity at least equal to the greater of:

(1) \$50,000; or

(2) the sum of two percent (2%) of the first \$7,500,000 of annualized premium revenues plus one percent (1%) of annualized premium revenues in excess of \$7,500,000; or

(3) an amount equal to the sum of:

(A) eight percent (8%) of the first \$7,500,000 of annualized health care expenditures, except those paid on a capitated or managed hospital payment basis; plus

(B) four percent (4%) of the annualized health care expenditures, except those paid on a capitated basis or managed hospital payment basis, which are in excess of \$7,500,000; plus

(C) four percent (4%) of annualized hospital expenditures paid on a managed hospital payment basis.

(c) For the purpose of this section "net equity" means the excess of total assets over total liabilities, excluding liabilities that have been subordinated in a manner acceptable to the Director. "Tangible net equity" means net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same

terms as equivalent transactions with nonaffiliates and which are not more than sixty (60) days past due; long term prepayments of deferred charges, and nonreturnable deposits. An obligation is fully secured for the purposes of this subsection if it is secured by tangible collateral, other than by securities of the plan or an affiliate, with an equity of at least one-hundred and ten percent (110%) percent of the amount owing.

(1) Beginning October 2, 2020, "positive tangible net equity" of an organization, as defined in Health and Safety Code section 1375.4(g), shall be at least equal to the greater of:

(A) one percent (1%) of annualized revenues; or

(B) four percent (4%) of annualized non-capitated medical expenses.

(2) The tangible net equity of an organization shall be determined pursuant to the criteria listed in subdivision (c) of this section.

(3) Beginning October 1, 2019 and ending October 1, 2020, an organization shall comply with the positive tangible net equity requirement of no less than one dollar (\$1.00).

(d) For the purpose of this section, "capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.

(e) For the purpose of this section, "managed hospital payment basis" means agreements wherein the financial risk is primarily related to the degree of utilization rather than to the cost of services.

Note: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1376, Health and Safety Code.

Quarterly Financial Survey Report Form

Schedule J

Notes to Financial Statements

Quarterly Financial Survey Report Form

RBO Details

1	<u>RBO</u>	
2	<u>Created By</u>	
3	<u>Date Created</u>	
4	<u>Date Completed</u>	
5	<u>Combining Schedules</u>	
6	<u>Report Status</u>	

7 Notes\Combining Schedules\Annual Audit Report Upload

(Document attached) - as needed.

Quarterly Financial Survey Report Form

Balance Sheet

Current Assets		Current Period
1	Cash and Cash Equivalents (Schedule A)	
2	Short-Term Investments	
3	HMO Capitation Receivable-Net (collectible within 30 days) (Schedule B)	
4	HMO Capitation Receivable-Net (collectible beyond 30 days) (Schedule B)	
5	Non-HMO/Fee-for-Service Receivable-Net (Schedule B)	
6	HMO Receivable-Net (collectible within 30 days) (Schedule B)	
7	HMO Receivable-Net (collectible beyond 30 days) (Schedule B)	
8	Risk Pool Receivable-Net (Schedule B)	
9	Other Incentive Program Receivables-Net (Schedule B)	
10	Secured Affiliate Receivable - Net (Schedule B)	
11	Unsecured Affiliate Receivable -Net (Schedule B)	
12	Other Receivable-Net (Schedule B)	
13	Other Current Assets	
14	Total Current Assets	
Other Assets		
15	Long-term Investments	
16	Intangible Assets and Goodwill - Net	
17	Risk Pool Receivable (Non-Current) (Schedule B)	
18	Other Incentive Program Receivables (Non-Current) (Schedule B)	
19	Secured Affiliate Receivables-Long-Term (Schedule B)	
20	Unsecured Affiliate Receivables-Long-Term (Schedule B)	
21	Other Non-Current Assets	
22	Total Other Assets	
23	Total Property and Equipment-Net	
24	Total Assets	
Current Liabilities		
25	Trade Accounts Payable	
26	Sub-Capitation Payable	
27	Claims Payable (excluding Incurred But Not Reported Claims)	
28	Incurred But Not Reported Claims (Schedule C)	
29	Withhold/Surplus Payable	
30	Other Medical Liability	
31	Loans and Notes Payable (Current)	
32	Amounts Due to Affiliates (Current)	
33	Other Current Liabilities	
34	Total Current Liabilities	
Other Liabilities		
35	Loans and Notes Payable (not subordinated) (Long-Term)	
36	Loans and Notes Payable (subordinated)	
37	Accrued Subordinated Interest Payable	
38	Amounts Due to Affiliates (Long-Term)	
39	Other Long-Term Liabilities	
40	Total Other Liabilities	
41	Total Liabilities	

Quarterly Financial Survey Report Form

	Net Worth	
42	Capital	
43	Additional Paid-In Capital	
44	Retained Earnings (deficit/fund balance)	
45	Other Net Worth Items	
46	Total Net Worth	
47	Total Liabilities and Net Worth	

	Statement of Net Worth	Current Period
1	Net Worth Beginning of Period	
2	Audit Adjustments	
3	Increase (Decrease) in Stock	
4	Increase (Decrease) in Additional Paid-In Capital	
5	Increase (Decrease) in Contributed Capital	
6	Increase (Decrease) in Retained Earnings	
7	Net Income (Loss)	
8	Distributions to Shareholders	
9	Changes in Other Net Worth Items	
10	Net Worth End of Period	

	Income Statement	Current Period	Year-To-Date
	Revenues		
1	HMO Revenue		
2	Non-HMO/Fee-for-Service Revenue		
3	Risk Pool Revenue (Schedule D)		
4	Other Incentive Pool Revenue (Schedule D)		
5	Other Revenue		
6	Total Revenue		
	Expenses		
7	Physician and Physician Extender - Salary & Benefits		
8	Medical Claims Expense		
9	Pharmacy Expense		
10	Other Medical Expenses (Capitated)		
11	Other Medical Expenses (Non-Capitated)		
12	Administration and Other Expenses (Schedule E)		
13	Total Expenses		
14	Income (Loss) Before Provision For Income Taxes		
15	Income Taxes		
16	Net Income (Loss)		

Quarterly Financial Survey Report Form

Statement of Cash Flows

Current Period

CASH FLOW PROVIDED (USED) BY OPERATING ACTIVITIES

1	Capitation Revenues	
2	Fee-for-Service Revenues	
3	Risk and Incentive Revenues	
4	Other Revenues	
5	Medical Expenses	
6	Administrative Expenses and Other Expenses	
7	Income Taxes	
8	Interest	
9	NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES	

CASH FLOW PROVIDED (USED) BY INVESTING ACTIVITIES

10	Investments	
11	Property, Plant and Equipment	
12	Other Long-Term Assets	
13	NET CASH PROVIDED (USED) BY INVESTING ACTIVITIES	

CASH FLOW PROVIDED (USED) BY FINANCING ACTIVITIES

14	Capital or Stock Issuance	
15	Loans (Affiliates)	
16	Loans (Non-Affiliates)	
17	Dividends Paid	
18	Other Financing Activities	
19	NET CASH PROVIDED (USED) BY FINANCING ACTIVITIES	
20	NET CASH INCREASE (DECREASE) IN CASH	
21	CASH AND CASH EQUIVALENTS AT BEGINNING OF THE QUARTER	
22	CASH AND CASH EQUIVALENTS AT END OF THE QUARTER	

RECONCILIATION OF NET INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES

23	Net Income	
----	------------	--

ADJUSTMENTS TO RECONCILE NET INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES

24	Depreciation and Amortization	
25	Decrease(Increase) In Receivables	
26	Decrease(Increase) In Prepaid Expenses	
27	Decrease(Increase) In Affiliated Receivables	
28	Decrease(Increase) In Accounts Payable	
29	Decrease(Increase) In Claims Payable and Shared Risk Pool	
30	Decrease(Increase) In Unearned Capitation	
31	Decrease(Increase) In Other Adjustments to Net Income	
32	TOTAL ADJUSTMENTS	
33	NET CASH PROVIDED BY OPERATING ACTIVITIES	

Quarterly Financial Survey Report Form

Grading Criteria

Tangible Net Equity		Current Period
1	Net Equity	
2	Add Subordinated Debt	
3	Less Receivables from officers, directors and affiliates	
4	Less Intangibles	
5	Tangible Net Equity	
6	Required Tangible Net Equity (Schedule I)	
7	Tangible Net Equity Excess (Deficiency)	
8	Maintained a positive Tangible Net Equity at all times, for the reporting period	

Working Capital		
9	Maintained a positive working capital at all times, for the reporting period	
10	Working capital must be calculated based on financial information at the last day of the reporting period	

Cash-to-Claims Ratio		
11	Maintained the required cash-to-claims ratio, at all times, for the reporting period (section 1300.75.4.2 (b)(5))	
12	Ratio must be based on financial information at the last day of the reporting period	

Claims and IBNR		
13	Did the RBO reimburse, contest or deny at least 95% of claims within 45 working days over the course of any three-month period?	
14	Enter percentage	
15	Methodology for Calculating IBNR	
16	If other, describe the methodology of calculating IBNR	
17	Has the RBO estimated and documented, on a monthly basis, its liability for IBNR claims?	
18	Are IBNR estimates the basis for the financial statement submission?	

Quarterly Financial Survey Report Form

Schedule A

Cash & Cash Equivalents

<u>Account Type</u> (*Indicate if Restricted)	<u>Type of Account</u>	<u>Balance (last day of the reporting period)</u>	<u>Asset Type</u>
	<u>Total of all balances* =</u>		

*should agree with Balance Sheet, Row 1

Quarterly Financial Survey Report Form

Schedule B

Receivables

Individually list all debtors with account balances greater than 10% of gross receivables. Group the total of all other receivables and enter the total on the line titled "Aggregate Accounts Not Individually Listed."

1 Name of Debtor	2 Unsecured Receivables (Normal Course of Business)	3 1-30 Days	4 31-60 Days	5 61-90 Days	6 Over 90 Days	7 Total
1						0
2						0
3						0
4						0
5						0
6						0
7						0
8						0
9						0
10						0
11						0
12						0
13						0
14						0
15						0
16						0
17						0
18						0
19						0
20						0
21						0
22						0
23						0
24						0
25						0
26						0
27						0
28						0
29						0
30						0
31						0
32						0
33 Total - Individual Listed Receivables			0	0	0	0

Quarterly Financial Survey Report Form

Schedule C

Explanation of the Method of Calculating the Provision for Incurred But Not Reported Claims

Provide a written explanation of the method of calculating the provision for Incurred But Not Reported claims for quarterly/fiscal year end claims liability accrual.

Quarterly Financial Survey Report Form

Schedule D

Risk Pool and Other Incentive Revenues

Name	Balance	Quarter Reported	Accrual (Y/N)	Received Date	Description

Quarterly Financial Survey Report Form

Schedule E

Administration and Other Expenses

Expenses	Current Period	Year-To-Date
Board Fees		
Bonuses to Physicians		
Depreciation/Amortization		
Distributions to Officers		
Income Tax Expense		
Interest Expense		
Management Fees-MSO		
Marketing Expense		
Salaries - Officers		
Salaries - Other		
Occupancy/Rent		
Other Expenses		
Total		

Quarterly Financial Survey Report Form

Schedule F

DETAILS OF ENROLLMENT

TOTAL ENROLLMENT

<u>Name of Health Plan or RBO</u>	<u>Commercial</u>	<u>Medicare Advantage</u>	<u>Medi-Cal</u>	<u>Total</u>
<u>Total Enrollment</u>				

Quarterly Financial Survey Report Form

Schedule G

Inventory of Claims to be Processed(Count)

<u>Month ending</u>	<u>Beginning Balance- Number of Claims in inventory on the 1st of the month</u>	<u>Add - Claims Received during the month</u>	<u>Deduct - Number of Claims Processed/A djudicated</u>	<u>Add/Deduct- Adjustments</u>	<u>Ending Balance - Number of claims in inventory at the end of the month</u>
<u>January</u>					
<u>February</u>					
<u>March</u>					
<u>April</u>					
<u>May</u>					
<u>June</u>					
<u>July</u>					
<u>August</u>					
<u>September</u>					
<u>October</u>					
<u>November</u>					
<u>December</u>					

Quarterly Financial Survey Report Form

Schedule I

REQUIRED TANGIBLE NET EQUITY (TNE) CALCULATION
TNE required must be equal to the Greater of "A" or "B"

		Current Period
A.	HEALTHCARE REVENUES	
	1% of annualized healthcare revenues	
B.	HEALTHCARE EXPENDITURES	
	4% of annualized healthcare expenditures	
	Required "TNE" - Greater of "A" or "B"	

TNE Calculation of Annualized Healthcare Revenues and Expenditures

	Annualized	Current QTR	1st Prior QTR	2nd Prior QTR	3rd Prior QTR
Annualized healthcare revenues					
Annualized healthcare expenditures					

Annual Financial Survey Report Form

Schedule D

Risk Pool and Other Incentive Revenues

<u>Name</u>	<u>Balance</u>	<u>Quarter Reported</u>	<u>Accrual (Y/N)</u>	<u>Received Date</u>	<u>Description</u>

Annual Financial Survey Report Form

RBO Details

1	<u>RBO</u>	
2	<u>Created By</u>	
3	<u>Date Created</u>	
4	<u>Date Completed</u>	
5	<u>Year</u>	
6	<u>Audit Opinion</u>	
7	<u>Combining Schedules</u>	
8	<u>Report Status</u>	

9	<u>Audit Firm</u>	
	<u>Firm Name</u>	
	<u>Contact First Name</u>	
	<u>Contact Last Name</u>	
	<u>Phone</u>	
	<u>Email</u>	

10	<u>Reinsurance and Professional Stop-Loss</u>	
	<u>Reinsurance</u>	
	<u>Professional Stop-Loss</u>	
	<u>Self Insure</u>	

11	<u>Notes\Combining Schedules\Annual Audit Report Upload</u>	
	<u>(Document attached) - as needed.</u>	

Annual Financial Survey Report Form

Statement of Organization (description of structure)

Statement of Organization -Detail

12	RBO Model	
13	Legal Ownership	
14	RBO Ownership	

MSO Information

Name	
Address	
City, State, Zip	
Contact Title	
Contact First Name	
Contact Last Name	
Contact Phone	
Contact Email	
MSO related to the RBO?	

Dispute Resolution Mechanism Contact

Address	
City, State, Zip	
Phone	
Website	

Counties Served by the RBO

--	--

RBO Lives Under Risk Arrangements

Commercial Percentage of RBO Lives Under Risk Arrangements	
Medicare Advantage Percentage of RBO Lives Under Risk Arrangements	
Medi-Cal Percentage of RBO Lives Under Risk Arrangements	
Total Percentage of All Capitated Lives (should = 100%)	
Total RBO Lives Under Risk Arrangements	
Total Primary Care Physicians in Employment or Under Contractual Arrangements	
Total Specialist Physicians in Employment or Under Contractual Arrangements	

Affiliate Information

Affiliate Business Name	
Affiliate Address	
City, State, Zip	

Annual Financial Survey Report Form

Contact First Name	
Contact Last Name	
Contact Phone	
Contact Email	

20 Contracted Health Plans

Health Plan	Commercial	Medicare Advantage	Medi-Cal

21 Contracted Organizations

Organization	Commercial	Medicare Advantage	Medi-Cal

22 Reimbursement for Specialists

Specialists	Type	% Capitated	% Fee for Service	% Salary or Retainer

23 Foundation Information

Name	
Address	
City, State, Zip	

Does the medical group directly contract with a health plan?	
Does the medical group arrange for health care services for enrollees?	
Does the medical group receive compensation on a capitated or fixed periodic payment basis?	

Annual Financial Survey Report Form

<p>Is the medical group directly responsible for the processing and payment of claims for services rendered under the capitated or fixed payment arrangement?</p>	
---	--

Total HMO Revenue	
Total Non-HMO Revenue	
Total Revenue	
Total Professional Fees	
All Other Expenses	
Total Expenses	

Annual Financial Survey Report Form

Balance Sheet

Current Assets		Current Period
1	Cash and Cash Equivalents (Schedule A)	
2	Short-Term Investments	
3	HMO Capitation Receivable-Net (collectible within 30 days) (Schedule B)	
4	HMO Capitation Receivable-Net (collectible beyond 30 days) (Schedule B)	
5	Non-HMO/Fee-for-Service Receivable-Net (Schedule B)	
6	HMO Receivable-Net (collectible within 30 days) (Schedule B)	
7	HMO Receivable-Net (collectible beyond 30 days) (Schedule B)	
8	Risk Pool Receivable-Net (Schedule B)	
9	Other Incentive Program Receivables-Net (Schedule B)	
10	Secured Affiliate Receivable - Net (Schedule B)	
11	Unsecured Affiliate Receivable -Net (Schedule B)	
12	Other Receivable-Net (Schedule B)	
13	Other Current Assets	
14	Total Current Assets	
Other Assets		
15	Long-term Investments	
16	Intangible Assets and Goodwill - Net	
17	Risk Pool Receivable (Non-Current) (Schedule B)	
18	Other Incentive Program Receivables (Non-Current) (Schedule B)	
19	Secured Affiliate Receivables-Long-Term (Schedule B)	
20	Unsecured Affiliate Receivables-Long-Term (Schedule B)	
21	Other Non-Current Assets	
22	Total Other Assets	
23	Total Property and Equipment-Net	
24	Total Assets	
Current Liabilities		
25	Trade Accounts Payable	
26	Sub-Capitation Payable	
27	Claims Payable (excluding Incurred But Not Reported Claims)	
28	Incurred But Not Reported Claims (Schedule C)	
29	Withhold/Surplus Payable	
30	Other Medical Liability	
31	Loans and Notes Payable (Current)	
32	Amounts Due to Affiliates (Current)	
33	Other Current Liabilities	
34	Total Current Liabilities	
Other Liabilities		
35	Loans and Notes Payable (not subordinated) (Long-Term)	
36	Loans and Notes Payable (subordinated)	

Annual Financial Survey Report Form

37	Accrued Subordinated Interest Payable	
38	Amounts Due to Affiliates (Long-Term)	
39	Other Long-Term Liabilities	
40	Total Other Liabilities	
41	Total Liabilities	
	Net Worth	
42	Capital	
43	Additional Paid-In Capital	
44	Retained Earnings (deficit/fund balance)	
45	Other Net Worth Items	
46	Total Net Worth	
47	Total Liabilities and Net Worth	

Statement of Net Worth		<u>Current Period</u>
1	Net Worth Beginning of Period	
2	Audit Adjustments	
3	Increase (Decrease) in Stock	
4	Increase (Decrease) in Additional Paid-In Capital	
5	Increase (Decrease) in Contributed Capital	
6	Increase (Decrease) in Retained Earnings	
7	Net Income (Loss)	
8	Distributions to Shareholders	
9	Changes in Other Net Worth Items	
10	Net Worth End of Period	

Income Statement		<u>Year-To-Date</u>
Revenues		
1	HMO Revenue	
2	Non-HMO/Fee-for-Service Revenue	
3	Risk Pool Revenue (Schedule D)	
4	Other Incentive Pool Revenue (Schedule D)	
5	Other Revenue	
6	Total Revenue	
Expenses		
7	Physician and Physician Extender - Salary & Benefits	
8	Medical Claims Expense	
9	Pharmacy Expense	
10	Other Medical Expenses (Capitated)	
11	Other Medical Expenses (Non-Capitated)	
12	Administration and Other Expenses (Schedule E)	
13	Total Expenses	
14	Income (Loss) Before Provision For Income Taxes	
15	Income Taxes	
16	Net Income (Loss)	

Annual Financial Survey Report Form

Statement of Cash Flows

Current Period

CASH FLOW PROVIDED (USED) BY OPERATING ACTIVITIES

1	Capitation Revenues	
2	Fee-for-Service Revenues	
3	Risk and Incentive Revenues	
4	Other Revenues	
5	Medical Expenses	
6	Administrative Expenses and Other Expenses	
7	Income Taxes	
8	Interest	
9	<u>NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES</u>	

CASH FLOW PROVIDED (USED) BY INVESTING ACTIVITIES

10	Investments	
11	Property, Plant and Equipment	
12	Other Long-Term Assets	
13	<u>NET CASH PROVIDED (USED) BY INVESTING ACTIVITIES</u>	

CASH FLOW PROVIDED (USED) BY FINANCING ACTIVITIES

14	Capital or Stock Issuance	
15	Loans (Affiliates)	
16	Loans (Non-Affiliates)	
17	Dividends Paid	
18	Other Financing Activities	
19	<u>NET CASH PROVIDED (USED) BY FINANCING ACTIVITIES</u>	
20	<u>NET CASH INCREASE (DECREASE) IN CASH</u>	
21	<u>CASH AND CASH EQUIVALENTS AT BEGINNING OF THE YEAR</u>	
22	<u>CASH AND CASH EQUIVALENTS AT END OF THE YEAR</u>	

RECONCILIATION OF NET INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES

23	Net Income	
----	------------	--

ADJUSTMENTS TO RECONCILE NET INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES

24	Depreciation and Amortization	
25	Decrease (Increase) In Receivables	
26	Decrease (Increase) In Prepaid Expenses	
27	Decrease (Increase) In Affiliated Receivables	
28	Decrease (Increase) In Accounts Payable	
29	Decrease (Increase) In Claims Payable and Shared Risk Pool	
30	Decrease (Increase) In Unearned Capitation	
31	Decrease (Increase) In Other Adjustments to Net Income	
32	<u>TOTAL ADJUSTMENTS</u>	
33	<u>NET CASH PROVIDED BY OPERATING ACTIVITIES</u>	

Annual Financial Survey Report Form

Grading Criteria

Tangible Net Equity		Current Period
1	<u>Net Equity</u>	
2	<u>Add Subordinated Debt</u>	
3	<u>Less Receivables from officers, directors and affiliates</u>	
4	<u>Less Intangibles</u>	
5	<u>Tangible Net Equity</u>	
6	<u>Required Tangible Net Equity (Schedule I)</u>	
7	<u>Tangible Net Equity Excess (Deficiency)</u>	
8	<u>Maintained a positive Tangible Net Equity at all times, for the reporting period</u>	

Working Capital		
9	<u>Maintained a positive working capital at all times, for the reporting period</u>	
10	<u>Working capital must be calculated based on financial information at the last day of the reporting period</u>	

Cash-to-Claims Ratio		
11	<u>Maintained the required cash-to-claims ratio, at all times, for the reporting period (section 1300.75.4.2 (c)(4))</u>	
12	<u>Ratio must be based on financial information at the last day of the reporting period</u>	

Claims and IBNR		
13	<u>Did the RBO reimburse, contest or deny at least 95% of claims within 45 working days over the course of any three-month period?</u>	
14	<u>Enter percentage</u>	
15	<u>Methodology for Calculating IBNR</u>	
16	<u>If other, describe the methodology of calculating IBNR</u>	
17	<u>Has the RBO estimated and documented, on a monthly basis, its liability for IBNR claims?</u>	
18	<u>Are IBNR estimates the basis for the financial statement submission?</u>	

Annual Financial Survey Report Form

Schedule B

Receivables

Individually list all debtors with account balances greater than 10% of gross Receivables. Group the total of all other receivables and enter the total on the line titled, "Aggregate Accounts Not Individually Listed."

	1 Name of Debtor	2 Unsecured Receivables (Normal Course of Business)	3 1-30 Days	4 31-60 Days	5 61-90 Days	6 Over 90 Days	7 Total
1							0
2							0
3							0
4							0
5							0
6							0
7							0
8							0
9							0
10							0
11							0
12							0
13							0
14							0
15							0
16							0
17							0
18							0
19							0
20							0
21							0
22							0
23							0
24							0
25							0
26							0
27							0
28							0

Annual Financial Survey Report Form

Schedule C

Explanation of the Method of Calculating the Provision for Incurred But Not Reported Claims

Provide a written explanation of the method of calculating the provision for Incurred But Not Reported claims for quarterly/fiscal year end claims liability accrual.

Annual Financial Survey Report Form

Schedule E

Administration and Other Expenses

<u>Expenses</u>	<u>Year-To-Date</u>
<u>Board Fees</u>	
<u>Bonuses to Physicians</u>	
<u>Depreciation/Amortization</u>	
<u>Distributions to Officers</u>	
<u>Income Tax Expense</u>	
<u>Interest Expense</u>	
<u>Management Fees-MSO</u>	
<u>Marketing Expense</u>	
<u>Salaries - Officers</u>	
<u>Salaries - Other</u>	
<u>Occupancy/Rent</u>	
<u>Other Expenses</u>	
<u>Total</u>	

Annual Financial Survey Report Form

Schedule F

DETAILS OF ENROLLMENT

TOTAL ENROLLMENT

<u>Name of Health Plan or RBO</u>	<u>Commercial</u>	<u>Medicare Advantage</u>	<u>Medi-Cal</u>	<u>Total</u>
<u>Total Enrollment</u>				

Annual Financial Survey Report Form

Schedule G

Inventory of Claims to be Processed(Count)

<u>Month ending</u>	<u>Beginning Balance- Number of Claims in inventory on the 1st of the month</u>	<u>Add - Claims Received during the month</u>	<u>Deduct - Number of Claims Processed/A djudicated</u>	<u>Add/Deduct- Adjustments</u>	<u>Ending Balance - Number of claims in inventory at the end of the month</u>
<u>January</u>					
<u>February</u>					
<u>March</u>					
<u>April</u>					
<u>May</u>					
<u>June</u>					
<u>July</u>					
<u>August</u>					
<u>September</u>					
<u>October</u>					
<u>November</u>					
<u>December</u>					

Annual Financial Survey Report Form

Schedule I

REQUIRED TANGIBLE NET EQUITY (TNE) CALCULATION
TNE required must be equal to the Greater of "A" or "B"

		Current Period
A.	HEALTHCARE REVENUES	
	1% of annualized healthcare revenues	
B.	HEALTHCARE EXPENDITURES	
	4% of annualized healthcare expenditures	
	Required "TNE" - Greater of "A" or "B"	

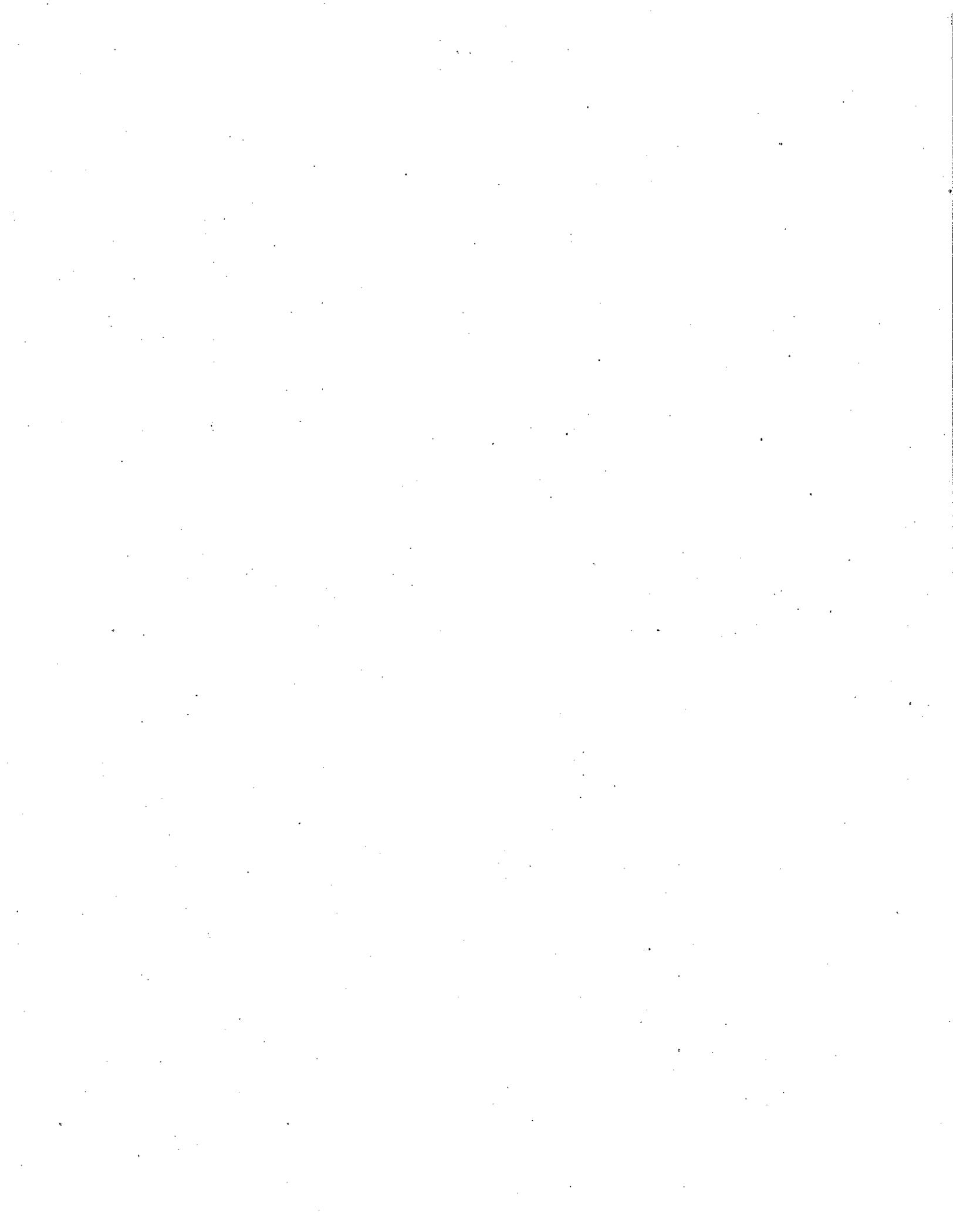
TNE Calculation of Annualized Healthcare Revenues and Expenditures

	Annualized	Current QTR	1st Prior QTR	2nd Prior QTR	3rd Prior QTR
Annualized healthcare revenues					
Annualized healthcare expenditures					

Annual Financial Survey Report Form

Schedule J

Notes to Financial Statements



<u>Date of CAP Report:</u>	
<u>RBO Number:</u>	
<u>RBO Name:</u>	
<u>RBO Contact Name and Title:</u>	
<u>RBO Contact Telephone:</u>	
<u>RBO Contact E-Mail Address:</u>	

<u>Grading Criteria:</u>	<u>Initial Quarter Deficient (MM/DD/YYYY)</u>	<u>Current Quarter Ended (MM/DD/YYYY)</u>	<u>Compliant with Final/Approved CAP (Y or N)</u>	<u>If Deficient, Reason for Deficiency</u>
<u>Tangible Net Equity (TNE)</u>				
<u>Required TNE</u>				
<u>Working Capital</u>				
<u>Cash-to-Claims Ratio</u>				
<u>Claims Timeliness</u>				
<u>Estimated & documented IBNR pursuant to a method specified in section 1300.77.2</u>	Y/N	Y/N		

By submitting this Corrective Action Plan (CAP), I hereby certify that to the best of my knowledge that the information provided in this CAP is true and accurate. This CAP contains financial projections and underlying assumptions, which are based on information that is dynamic in nature and subject to rapid and sometimes abrupt changes. As these projections and underlying assumptions are subject to a number of risks and uncertainties, actual results may differ materially from those stated or implied. I undertake to advise the DMHC and contracting health plan(s) of any event or events that will materially affect the organization's ability to remain compliant with the requirements of the CAP within a period of five days from such event.

PRINCIPAL OFFICER: _____

Specific Actions Being Taken/Implemented <i>(Enter a complete description of actions being taken or steps implemented to resolve the deficiency)</i>	Assistance From Contracting Health Plans or Sub-Delegating Organizations <i>(List any written representations made by contracting health plans or sub-delegating organizations to assist the organization in the implementation of the CAP.)</i>	Expected Results & Milestones <i>(Enter expected results of actions taken; include monthly/quarterly milestones)</i>	Estimated Date of Completion for Each Specific Action <i>(Enter expected date of completion)</i>	Deficiencies Addressed <i>(Enter deficiencies addressed above, may be more than one per action item)</i>	Progress Achieved To Date <i>(Enter progress achieved as of the date of this report)</i>
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

DESCRIPTION OF ASSUMPTIONS USED IN DEVELOPMENT OF PROJECTIONS (INCLUDE ALL SUPPORTING SCHEDULES AND DOCUMENTS AS ATTACHMENTS TO CAP)

1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

List of all plans and sub-delegating organizations with which the Organization has contracts involving a risk arrangement:

Name of the plan or sub-delegating organization	Title & Name of Person responsible for monitoring CAP compliance	Telephone	Postal Address	Email Address
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

**General Information for the DMHC Annual Financial
Survey Report Form**

An organization shall submit this form to the DMHC not more than one-hundred and fifty (150) days after the close of the organization's fiscal year and not more than one-hundred and fifty (150) days after the close of each of the organization's subsequent fiscal years. The information submitted on the form shall be based upon the organization's annual audited financial statement prepared in accordance with generally accepted accounting principles (GAAP). Below are general guidelines for filling out the form.¹

Page 1. RBO Details.

- Items 1-8: Please provide identifying information for the RBO. For Items 6-8, provide the type of applicable audit opinion, e.g., unqualified opinion, qualified opinion, disclaimer of opinion, or adverse opinion. In Item 7, explain whether the annual financial survey report is on a combining basis with an affiliate or entity. In Item 8, indicate whether the Annual Financial Survey Report is open or whether it has been completed.
- Item 10: Please indicate what type of management of risk arrangements the organization uses.
- Item 11: Attach any applicable documents.

Page 2. Statement of Organization (Description of Structure)

- Items 12-14: Please disclose the provider organization and model type. For RBO model, indicate whether the RBO is an IPA, a medical group, an IPA/Medical group combination, foundation, or other. For legal ownership, indicate whether the type of ownership is a professional corporation, a partnership, not-for-profit, foundation, sole proprietorship, or other. For RBO ownership, indicate whether the RBO is partially or wholly owned by a hospital or healthcare system. If there is a partial or whole ownership by a hospital or healthcare system, please provide additional information regarding the hospital or healthcare system.
- Item 15: If the organization is using a management services organization (MSO), please provide the information of the MSO utilized by the organization.

Page 2. Dispute Resolution Mechanism

¹ Please note the general information documents only include those items where additional description may assist the party filling out the form. Therefore, not all portions of the form are described in the general information document.

- Item 16: Please provide information regarding the RBOs' provider dispute resolution mechanism where providers access written information and instructions for filing provider disputes.

Page 2. RBO Lives Under Risk Arrangement

- Item 18: Please indicate the percentage of RBO lives in commercial, Medicare, and Medi-Cal. In the last two lines, indicate the number of primary care physicians and specialty physicians employed or under contract with the RBO.

Pages 2 - 3. Affiliate Information

- Item 19: If applicable, please provide information regarding an affiliate of the RBO.

Page 3. Reimbursement for Specialists

- Item 22: Please disclose how the RBO compensates each type of specialist. Please list the specialist in the first column. In the second column list the "type" of product the specialist is compensated for i.e., commercial, Medicare Advantage or Medi-Cal. Do not disclose the actual fee rather only disclose the type of fee paid in a percentage form.

Pages 3 - 4. Foundation Information

- Item 23: Numerical data: For total HMO revenue, please provide revenue received from HMOs including withholds, refunds, insurance services, capitation, and copayments received from the HMO on an ongoing basis. For total Non-HMO Revenue, provide the fee-for-service revenue including the Preferred Provider Organization, Health Savings Account and cash payments, net of contractual and bad debt allowances.
- Item 23. For total revenue, provide the sum of all revenues for the medical group. For total professional fees, provide the sum of all healthcare costs incurred by the medical group. For all other expenses, provide the sum of all administrative and other expenses which can include administrative services, compensation and fringe benefits, interest expenses, occupancy, depreciation/amortization, management fees, marketing and income taxes.

Page 5. Financials

Balance Sheet: Current Assets. List assets available to the RBO during the current period as follows:

- Line 2: Short term investments: provide readily available investments acquired with temporarily unneeded cash.
- Line 3: HMO Capitation Receivable-Net (collectible within 30 days) (Schedule B): Provide gross amounts collectible from HMOs expected to be collected within 30

days, less the amount accrued for receivables determined to be uncollectible during the period. Include receivables from HMO, such as withholds, refunds, and capitation or fixed periodic payments, but do not include risk receivables.

- Line 4: HMO Capitation Receivable-Net (collectible beyond 30 days) (Schedule B): Provide gross amounts collectible from HMOs through a capitated or fixed periodic payment, less the amount accrued for receivables, including withholds, refunds, and capitation or fixed periodic payments, determined to be uncollectible during the 30-day period.
- Line 5: Non-HMO/Fee-for-Service Receivable – Net (Schedule B): Provide billings for patient care provided directly by the organization and due from third parties or patients, less the amounts accrued for receivables determined to be uncollected during the period.
- Line 6: HMO Receivable-Net (Schedule B) (collectible within 30 days): Provide gross amounts collectible from HMOs for receivables other than those through a capitated or fixed periodic payment, such as withholds and refunds.
- Line 7: HMO Receivable-Net (Schedule B) (collectible beyond 30 days): Provide gross amounts collectible from HMOs for receivables other than those through a capitated or fixed periodic payment, such as withholds and refunds.
- Line 8: Risk Pool Receivable – Net (Schedule B): Provide amounts expected to be collected within the fiscal year, under any risk pool arrangement, such as pharmacy, institutional risk, point-of-service (POS), and professional pools, less the amount accrued for receivables determined to be uncollectible during the period.
- Line 9: Other Incentive Program Receivables – Net (Schedule B): Provide amounts collectible for the reporting organization’s incentive receivables, which includes pay-for-performance receivables, less the amount accrued for receivables determined to be uncollectible during the period.
- Line 10: Secured Affiliate Receivable - Net (Schedule B): Provide amounts of secured current accounts receivable from parent, subsidiary, and/or affiliates For Department reporting, “Secured Affiliate Receivable” is the obligation that is fully secured by tangible collateral, other than by securities of the plan or the affiliate, with equity of at least 110 percent of the amount owing. This includes short-term obligations of affiliates for goods or services arising in the normal course of business, which is, payable on the same terms as equivalent transactions with nonaffiliated entities and which are not past due.
- Line 11: Unsecured Affiliate Receivable – Net (Schedule B): Provide any unsecured affiliate accounts receivable from parent, subsidiary and/or affiliates. This does not include short-term obligations of affiliates for goods or services

arising in the normal course of business, which are payable on the same terms as equivalent transactions with nonaffiliated entities and which are not past due.

- Line 12: Other Receivable-Net (Schedule B): Provide gross amounts expected to be collected from other sources not previously disclosed, less amounts accrued for receivables.
- Line 13: Other Current Assets: Provide other current assets including prepayments, supply inventories and other items that are not included in the current asset categories. If the total of this line is more than 15% of all current assets reported on lines 1-13, the itemization for this line item must include the details (description and amount).
- Line 14: Total Current Assets: Provide the total of the above listed categories in lines 1-13.

Page 5. Balance Sheet: Other Assets

Lines 15 through 24 account for other assets not listed in Lines 1 through 14.

- Line 16: Intangible Assets and Goodwill-Net: Provide assets of no physical substance; may include goodwill, software, covenants not to compete, patents, copyrights, licenses, franchises, etc., all net of accumulated amortization.
- Line 17: Risk Pool Receivable (Non-Current) (Schedule B): Provide amounts that will not materialize within the fiscal year, under any risk pool arrangement, less the amount accrued for receivables determined to be uncollectible during the period.
- Line 18: Other Incentive Program Receivables (Non-Current) (Schedule B): Provide amounts collectible for the organization's incentive receivables, net of bad debt allowances.
- Line 19: Secured Affiliate Receivables - Long-Term (Schedule B): Provide any secured non-current (over 365 days) accounts receivable from a parent, subsidiary and/or affiliates.
- Line 20: Unsecured Affiliate Receivables – Long-Term (Schedule B): Provide any unsecured non-current accounts receivable that is past due from parent, subsidiary and/or affiliate.
- Line 21: Other Non-Current Assets: Provide other non-current assets that not reported in previous categories. If the total of this line is more than 15% of all non-current assets reported on lines 15-21, the itemization for this line item must include the details (description and amount).

- Line 22: Total Other Assets: Provide the total of the above listed categories in lines 15-21.
- Line 24: Total Assets: Provide the total of lines 14, 22, and 23.

Page 5. Balance Sheet: Current Liabilities

Lines 25-34 account for the RBOs current liabilities.

- Line 25: Trade Accounts Payable: Provide the amounts due to creditors for the acquisition of goods and services, including trade and vendors rather than health care providers, on a credit basis.
- Line 26: Sub-Capitation Payable: Provide the amounts due to capitated providers (i.e. physicians, medical groups/IPAs, etc.) for medical services rendered to enrollees of the organization.
- Line 27: Claims Payable (excluding Incurred But Not Reported Claims): Provide claims received but not paid, but not including Incurred But Not Reported Claims, pursuant to section 1300.77.4.
- Line 28: Incurred But Not Reported Claims (Schedule C): Provide an estimate for claims that are incurred as of the date of statement preparation for which the organization is responsible but has not yet determined the specific amount of the liability.
- Line 29: Withhold/Surplus Payable: Provide amounts accrued, typically as withholds from fee-for-service, sub-capitation payments, risk pool surplus, or bonuses expected to be paid to contracted physicians.
- Line 30: Other Medical Liability: Provide all other medical liabilities due not reported in the above categories.
- Line 31: Loans and Notes Payable (Current): Provide the principal amount due on loans and notes payable within one year.
- Line 32: Amounts Due to Affiliates (Current): Provide liabilities owed to affiliates in the normal course of business.
- Line 33: Other Current Liabilities: Provide all other current liabilities. Include all items that are not included in the current liability categories. If the total of this line is more than 15% of all current liabilities reported on lines 25-33, the itemization for this line item must include the details (description and amount).
- Line 34: Total Current Liabilities: Provide the total of the liabilities listed in lines 25-33.

Pages 5 – 6. Balance Sheet: Other Liabilities

In Lines 35-41, please provide other liabilities of the RBO not previously listed for the current period.

- Line 35: Loans and Notes Payable (not subordinated) (Long-Term): Provide the principal amount due on loans and notes signed by the organization, not including the current portion payable.
- Line 36: Loans and Notes Payable (subordinated): Provide the principal amount due on loans and notes that are subordinated, including the current portion.
- Line 37: Accrued Subordinated Interest Payable: Provide the accrued interest due on any subordinated loan and/or notes.
- Line 39: Other Long-Term Liabilities: Provide all other long-term liabilities that are not included above. If the total of this line is more than 15% of all other liabilities reported on lines 35-39, the itemization for this line item must include the details (description and amount).
- Line 40: Total Other Liabilities: Provide the total of the liabilities listed in lines 35 – 39.
- Line 41: Total Liabilities: Provide the total of the liabilities in lines 34 and 40.

Page 6. Balance Sheet: Net Worth

Lines 42-47 require information regarding the RBOs net worth.

- Line 42: Capital: Provide the cumulative amount of capital contributions including stock.
- Line 43: Additional Paid-In Capital: Provide the excess amount of capital contributions for the period (including paid-in capital over stock par or stated value).
- Line 44: Retained Earnings (deficit/fund balance): Provide the cumulative earnings or deficit from operations, net of reserves and restricted funds.
- Line 45: Other Net Worth Items: Provide all other net worth items that are not included above.

- Line 46: Total Net Worth: Provide the total of Net Worth Categories in lines 42 – 45.
- Line 47: Total Liabilities and Net Worth: Provide the total of Total Liabilities and Net Worth (line 41 and line 46).

Page 6. Statement of Net Worth- Current Period

Lines 1-10 require additional details regarding Net Worth.

- Line 1: Net Worth Beginning of Period: Provide the starting value carried over from the previous fiscal year.
- Line 3: Increase (Decrease) in Stock: Provide any adjustment to the value of the organization's stock.
- Line 4: Increase (Decrease) in Additional Paid-In Capital: Provide additional capital paid-in to the organization or any loss of capital paid-in to the organization.
- Line 5: Increase (Decrease) in Contributed Capital: Provide capital contributed or lost to the organization during that period.
- Line 7: Net Income (Loss): Provide the value reported in line 14 of the Income Statement.
- Line 8: Distributions to Shareholders: Provide the value of any distributions to shareholders that occurred during that period and, therefore, reduced the assets available to the organization.
- Line 10: Net Worth End of Period: Provide the sum of the changes to net worth at the end of the period.

Page 6. Income Statement- Year-to Date

Lines 1-6 require the RBOs revenues.

- Line 1: HMO Revenue: Provide revenue received from HMOs including withholds, refunds, insurance services, capitation, co-payments that are received on an ongoing basis.
- Line 2: Non-HMO/Fee-for-Service Revenue: Provide fee-for-service revenue including Preferred Provider Organization, Health Savings Account, and cash payments, net of contractual and bad debt allowances.

- Line 3: Risk Pool Revenue (Schedule D): Provide revenue earned from risk-sharing contracts. The reporting entity may have contracts that contain certain shared-risk provisions whereby the organization can earn additional incentive revenue based upon the utilization of services by the reporting entity's enrollees.
- Line 5: Other Revenue: Provide any other source of revenues not listed.
- Line 6: Total Revenue: Provide the sum of all revenue categories in lines 1-5.

Lines 7-16 require information regarding the RBOs expenses.

- Line 7: Physician and Physician Extender-Salary & Benefits: Provide the salary and benefit cost of all physician and physician- extenders, which includes optometrists, chiropractors, doctors of osteopathy, nurse practitioners and physician assistants.
- Line 8: Medical Claims Expense: Provide all fee-for-service claim expenses for contracted and non-contracted providers whether actually paid, accrued or calculated in the IBNR estimate, disclosed in the Balance Sheet.
- Line 9: Pharmacy Expense: Provide fees incurred by the organization for providing prescription drugs to enrollees.
- Line 10: Other Medical Expenses (Capitated): Provide all other capitated medical professional services not reported above.
- Line 11: Other Medical Expenses (Non-Capitated): Provide all other non-capitated medical professional services not reported above.
- Line 12: Administration and Other Expenses (Schedule E): Include all administrative and other expenses not listed in the lines above including administrative services compensation and fringe benefits, interest expenses, occupancy, depreciation/amortization, management fees, marketing, bonuses, and income taxes.
- Line 13: Total Expenses: Provide the sum of the expenses listed in lines 7 – 12.
- Line 14: Income (Loss) Before Provision for Income Taxes: Provide the earnings or loss before taxes, expressed as line 6 minus line 13.
- Line 15: Income Taxes: Provide an estimate of taxes levied by the government on income for the organization.

- Line 16: Net Income (Loss): Provide the earnings after all expenses and taxes are deducted.

Page 7. Statements of Cash Flow

Statement of Cash Flows for Current Period- Please use this section to demonstrate the changes in cash flow as classified by operating, investing, and financing activities including reconciliation and adjustments to net cash provided by operating activities.

CASH FLOW PROVIDED (USED) BY OPERATING ACTIVITIES

- Line 1: Capitation Revenues: Provide the amount of cash or cash equivalents an organization receives from HMOs.
- Line 2: Fee-for-Service Revenues: Provide the amount of cash or cash equivalents an organization receives on a fee-for-service basis.
- Line 3: Risk and Incentive Revenues: Provide the amount of cash or cash equivalents an organization receives from risk-sharing and incentive contracts.
- Line 4: Other Revenues: Provide the amount of cash or cash equivalents an organization receives from other revenue sources.
- Line 5: Medical Expenses: Provide the amount of cash or cash equivalents an organization uses to pay medical expenses.
- Line 6: Administrative Expenses and Other Expenses: Provide the amount of cash or cash equivalents an organization uses to pay administrative expenses.
- Line 7: Income Taxes: Provide the amount of cash or cash equivalents an organization receives or uses from federal income taxes.
- Line 8: Interest: Provide the amount of cash or cash equivalents an organization receives or uses from investment and loans.
- Line 9: NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES: Provide the amount of cash or cash equivalents an organization receives or uses to pay ongoing operating expenses.

CASH FLOW PROVIDED (USED) BY INVESTING ACTIVITIES

- Line 10: Investments: Provide the amount of cash or cash equivalents an organization receives or uses from the purchase or sale of Investments (non-Trading).

- Line 12: Other Long-Term Assets: Provide the amount of cash or cash equivalents an organization receives or uses from the purchase or sale of other long-term assets.

CASH FLOW PROVIDED (USED) BY FINANCING ACTIVITIES

- Line 17: Dividends Paid: Provide the amount of cash or cash equivalents an organization uses for dividend payments to shareholders.
- Line 18: Other Financing Activities: Provide the amount of cash or cash equivalents an organization receives or uses for Other Financing Activities.
- Line 19: NET CASH PROVIDED (USED) BY FINANCING ACTIVITIES: Provide the amount of cash or cash equivalents an organization receives or uses to pay ongoing financing activities.
- Line 20: NET CASH INCREASE (DECREASE) IN CASH: The sum of the change in cash or cash equivalents the organization experienced during the reporting period.
- Line 21: CASH AND CASH EQUIVALENTS AT BEGINNING OF THE YEAR: Provide the amount of cash and cash equivalents an organization had at the beginning of the reporting period.
- Line 22: CASH AND CASH EQUIVALENTS AT END OF THE YEAR: Provide the amount of cash and cash equivalents an organization had at the end of the reporting period.

RECONCILIATION OF NET INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES

- Line 23: Provide the excess or deficiency of total revenues over total expenses.

ADJUSTMENTS TO RECONCILE NET INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES

- Line 24: Depreciation and Amortization: Adjust depreciation and amortization (non-cash expenses) from net income to determine net cash provided by operating activities.
- Line 25: Decrease (Increase) In Receivables: Adjust changes in receivables from net income to determine net cash provided by operating activities.
- Line 26: Decrease (Increase) In Prepaid Expenses: Adjust changes in prepaid

expenses from net income to determine net cash provided by operating activities.

- Line 27: Decrease (Increase) In Affiliated Receivables: Adjust changes in affiliated receivables from net income to determine net cash provided by operating activities.
- Line 28: Decrease (Increase) In Accounts Payable: Adjust changes in accounts payable from net income to determine net cash provided by operating activities.
- Line 29: Decrease (Increase) In Claims Payable and Shared Risk Pool: Adjust changes in claims payable and shared risk pool from net income to determine net cash provided by operating activities.
- Line 30: Decrease (Increase) In Unearned Capitation: Adjust changes in unearned capitation from net income to determine net cash provided by operating activities.
- Line 31: Decrease (Increase) In Other Adjustments to Net Income: Use to determine any other adjustments to net income needed to reconcile to net cash provided by operating activities.
- Line 32: TOTAL ADJUSTMENTS: Provide the sum of all adjustments to Net Income listed in lines 24-31.
- Line 33: NET CASH PROVIDED BY OPERATING ACTIVITIES: Provide the amount of cash or cash equivalents an organization receives or uses to pay ongoing operating expenses.

Page 8. Grading Criteria

Tangible Net Equity- Please self-attest whether positive TNE was maintained during the reporting period pursuant to section 1300.75.4.2(c)(3).

- Line 1: Net Equity: Provide the financial information taken from Line 46 of the Balance Sheet-Net Worth.
- Line 2: Add Subordinated Debt: provide the information from Line 36 of the Balance Sheet-Other Liabilities.
- Line 3: Less Receivables from officers, directors and affiliates: Provide the information from Lines 11 (Current Assets) and 20 (Other Assets) of the Balance Sheet.
- Line 4: Less Intangibles: Provide the information from Line 16 (Other Assets) of the Balance Sheet.

- Line 5: Tangible Net Equity: Provide the amount calculated from Lines 1-4 directly above.
- Line 6: Required Tangible Net Equity (Schedule I): Provide required TNE by using Schedule I.
- Line 7: State the TNE Excess or Deficiency by using Schedule I.
- Line 8: Maintained a positive TNE at all times, for the reporting period: State "Yes" or "No" if compliant with the TNE requirement at all times during the reporting period.

Working Capital- Self-attest as to whether the working capital requirements were maintained pursuant to the solvency regulations section 1300.75.4.2(c)(3).

- Line 9: Maintained a positive working capital at all times, for the reporting period: State "Yes" or "No" if compliant with the working capital requirement at all times during the reporting period.
- Line 10: Provide working capital calculation.

Cash-to-Claims Ratio

- Line 11: State "Yes" or "No".
- Line 12: Provide cash-to-claims ratio calculation.

Claims and IBNR- Self-attest to the timeframe in which the RBO paid claims and the methodology for calculating IBNR pursuant to 1300.75.4.2(c)(2).

- Line 13: State "Yes" or "No".
- Line 14: Enter compliance percentage for claims timeliness.
- Line 15: Provide the methodology for calculating IBNR. Examples are lag study, actuarial, estimation or other.
- Line 16: If other, describe the methodology of calculating IBNR.
- Line 17: State if the RBO estimated and documented its liability for IBNR claims pursuant to a method specified in section 1300.77.2.
- Line 18: State "Yes" or "No".

Pages 9-19. Schedules A through Schedule J

- Schedule A- Enter details from the Balance Sheet, Line 1.
- Schedule B- Provide the requested information regarding receivables that were reported in the Balance Sheet.
- Schedule C- Provide an explanation for the method of calculating the provision for IBNR.
- Schedule D- Provide the information reported in the Balance Sheet- Income Statement for risk pool and other incentive revenues, Lines 3 and 4.
- Schedule E- Provide the information for administration and other expenses reported in Balance Sheet- Income Statement- Line 12.
- Schedule F- Provide the total enrollment, by product (commercial, Medicare Advantage, Medi-Cal) for which the organization is responsible for health care services provided.
- Schedule G- Provide information regarding the inventory (inflows and outflows) of claims processed on a monthly basis.
- Schedule H- List any mergers, acquisitions or discontinued operations during the reporting period.
- Schedule I- Provide the Tangible Net Equity Requirement
 - Item A: HEALTHCARE REVENUES is the calculation used to determine the required TNE threshold, as determined by annualized healthcare revenues. Annualized healthcare revenues are the summation of HMO Revenues (Line 1), Risk Pool Revenues (Line 3) and Other Incentive Pool Revenues (Line 4) of the Income Statement. Healthcare revenues are annualized from the most recent four quarter period. Schedule I requires the calculation of 1% of annualized healthcare revenues.
 - Item B: HEALTHCARE EXPENDITURES is the calculation used to report the non-capitated medical expenses. Healthcare expenditures are the summation of Medical Claims Expense (Line 8), Pharmacy Expense (Line 9), and Other Medical Expenses (Non-Capitated) (Line 11) of the Income Statement. Healthcare expenditures are annualized from the most recent four quarter period. Schedule I requires the calculation of 4% of annualized healthcare expenditures.”
 - Required TNE is the greater of healthcare revenues or healthcare expenditures, as calculated above.

- TNE Calculation of Annualized Healthcare Revenues and Expenditures is the annualized healthcare revenues and annualized healthcare expenditures on a quarterly and annualized basis.
- Schedule J: Provide any notes used for the financial statements.

General Information
DMHC Corrective Action Plan Form

Below is general information for the purposes of filling out this section of the form.¹

Grading Criteria

- Page 1. Please include the required solvency information based on the initial deficient quarter, the end of the current quarter, and whether the organization is compliant with the final/approved CAP. All portions of the Grading Criteria should be completed.

RBO Quarterly Financial Survey- Corrective Action Plan (CAP)

Description of Financial Assumptions

- Page 2. Explain how the financial assumption projections were developed. This information is necessary for the Department, health plans, and sub-delegating organizations to understand how an organization will reach compliance with the grading criteria.

CAP Financial Projections and Assumptions

- Page 3. Balance Sheet- Please complete each portion of the Balance Sheet with the requested information. Below is general information for filling out this section of the CAP.
 - Row 9: Secured Affiliate Receivable – Net: “Secured Affiliate Receivable” is the obligation that is fully secured by tangible collateral, other than by securities of the plan or the affiliate, with equity of at least 110 percent of the amount owing. This includes short-term obligations of affiliates for goods or services arising in the normal course of business, which is, payable on the same terms as equivalent transactions with nonaffiliated entities and which are not past due.
 - Row 10: Unsecured Affiliate Receivable – Net: Provide any unsecured affiliate accounts receivable from the parent, subsidiary and/or affiliates. This does not include short-term obligations of affiliates for goods or services arising in the normal course of business, which are payable on

¹ Please note the general information documents only include those items where additional description may assist the party filling out the form. Therefore, not all portions of the form are described in the general information document.

the same terms as equivalent transactions with nonaffiliated entities and which are not past due.

- Row 13: Total Current Assets is the total of the above listed categories in Row 1-12.
- Page 3. Balance Sheet- Other Assets. Below is general information for the purposes of filling out this section of the CAP.
 - Row 14: Long-term Investments: List investments intended to be held for a period longer than twelve months.
 - Row 16: Risk Pool Receivable (Non-Current): Provide amounts which will not materialize within the fiscal year less the amount accrued for receivables determined to be uncollectible during the period.
 - Row 17: Other Incentive Program Receivables (Non-Current): Provide amounts collectible for the organization's incentive receivables, net of bad debt allowances.
 - Row 21: Total Other Assets: List the total of the above listed categories in rows 14-20.
 - Row 22: Total Property and Equipment-Net: Provide all property, plant, and equipment, net of accumulated depreciation.
 - Row 23: Total Assets: Provide is the total of rows 13, 21, and 22.
- Pages 2-3. Balance Sheet- Current Liabilities. Below is general information for the purposes of filling out this section of the CAP.
 - Row 24: Trade Accounts Payable: Provide any amounts due to creditors for the acquisition of goods and services, including trade and vendors rather than health care providers, on a credit basis.
 - Row 25: Sub-Capitation Payable: Provide any amounts due to capitated providers (i.e. physicians, medical groups/IPAs, etc.) for medical services rendered to enrollees of the organization.
 - Row 27: Incurred But Not Reported Claims: Provide an estimate for claims that have been incurred as of the date of statement preparation for which the organization is responsible but has not yet determined the specific amount of the liability.

- Row 28: Withhold/Surplus Payable: Provide any amounts accrued, typically as withholds from fee-for-service, sub-capitation payments, risk pool surplus, or bonuses expected to be paid to contracted physicians.
- Row 32: Other Current Liabilities: Provide all other current liabilities. Include all items that are not included in the current liability categories.
- Row 33: **Total Current Liabilities:** Provide the total of the rows 24-32.
- Page 3. Balance Sheet-Other Liabilities. Below is general information for the purposes of filling out this section of the CAP.
 - Row 34: Loans and Notes Payable (not subordinated) (Long-Term): Provide the principal amount due on loans and notes signed by the organization, not including the current portion payable.
 - Row 35: Loans and Notes Payable (subordinated): Provide the principal amount due on loans and notes that are subordinated, including the current portion.
 - Row 38: Other Long-Term Liabilities: Provide all other long-term liabilities that are not included in other categories of this section.
 - Row 39: **Total Other Liabilities:** Provide the total of the liabilities listed in rows 34-38.
 - Row 40: **Total Liabilities:** Provide the total of the liabilities listed in rows 33 and 39.
- Page 3. Balance Sheet- Net Worth. Below is general information for the purposes of filling out this section of the CAP.
 - Row 41: Capital: Provide the cumulative amount of capital contributions including stock.
 - Row 42: Additional Paid-In Capital: Provide the excess amount of capital contributions for the period (including paid-in capital over stock par or stated value).
 - Row 45: **Total Net Worth:** Provide the total of Net Worth Categories in rows 41 – 44.
 - Row 46: **Total Liabilities and Net Worth:** Provide the total of Total Liabilities and Net Worth (row 40 and row 45).

- Page 3. Statement of Net Worth. Below is general information for the purposes of filling out this section of the CAP.
 - Row 1: Net Worth Beginning of Period: Provide the starting value carried over from the previous quarter.
 - Row 3: Increase (Decrease) in Stock: Provide any adjustment to the value of the organization's stock, if any.
 - Row 4: Increase (Decrease) in Additional Paid-In Capital: Provide any additional capital paid-in to the organization, if any, or any loss of capital paid-in to the organization.
 - Row 8: Distributions to Shareholders: Provide the value of any distributions to shareholders that occurred during that period and, therefore, reduce the assets available to the organization.
 - Row 10: Net Worth End of Period: Provide the sum of the changes to net worth at the end of the period.

- Pages 4-5. Income Statement-Revenues. Below is general information for the purposes of filling out this section of the CAP.
 - Row 1: HMO Revenue: Provide revenue received from HMOs including withholds, refunds, insurance services, capitation, co-payments that are received on an ongoing basis.
 - Row 2: Non-HMO/Fee-for-Service Revenue: Provide fee-for-service revenue including Preferred Provider Organization, Health Savings Account, and cash payments, net of contractual and bad debt allowances.
 - Row 3: Risk Pool Revenue: Provide revenue earned from risk-sharing contracts. The reporting entity may have contracts that contain certain shared-risk provisions whereby the organization can earn additional incentive revenue based upon the utilization of services by the reporting entity's enrollees.
 - Row 6: Total Revenue: Provide the sum of all revenue categories in rows 1-5.

- Page 5. Income Statement-Expenses. Below is general information for the purposes of filling out this section of the CAP.
 - Row 7: Physician and Physician Extender - Salary & Benefits: Provide the salary and benefit cost of all physician and physician- extenders, which includes optometrists, chiropractors, doctors of osteopathy, nurse practitioners and physician assistants.

- Row 8: Medical Claims Expense: Provide all fee-for-service claim expenses for contracted and non-contracted providers whether actually paid, accrued, or calculated in the IBNR estimate, disclosed in the Balance Sheet above.
 - Row 12: Administration and Other Expenses: Include all administrative and other expenses not listed in the rows above including administrative services compensation and fringe benefits, interest expenses, occupancy, depreciation/amortization, management fees, marketing, bonuses, and income taxes.
 - Row 13: Total Expenses: Provide is the sum of the expenses listed in rows 7 – 12.
 - Row 14: Income (Loss) Before Provision For Income Taxes: Provide the earnings or loss before taxes, expressed as row 93 minus row 102.
 - Row 15: Income Taxes: Provide an estimate of taxes levied by the government on income for the organization.
 - Row 16: Net Income (Loss): Provide the earnings after all expenses and taxes are deducted.
- Pages 5-6. Statement of Cash Flows. Below is general information for the purposes of filling out this section of the CAP.

Cash Flow Provided (Used) by Operating Activities

- Row 1: Capitation Revenues: Provide the amount of cash or cash equivalents an organization receives from HMOs.
- Row 2: Fee-for-Service Revenues: Provide the amount of cash or cash equivalents an organization receives on a fee-for-service basis.
- Row 3: Risk and Incentive Revenues: Provide the amount of cash or cash equivalents an organization receives from risk-sharing and incentive contracts.
- Row 9: NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES: Provide the amount of cash or cash equivalents an organization receives or uses to pay ongoing operating expenses.

Cash Flow Provided (Used) by Investing Activities

- Row 10: Investments: Provide the amount of cash or cash equivalents an

organization receives or uses from the purchase or sale of investments (non-trading).

- Row 13: NET CASH PROVIDED (USED) BY INVESTING ACTIVITIES: Provide the amount of cash or cash equivalents an organization receives or uses to pay ongoing investing activities.

Cash Flow Provided (Used) by Financing Activities

- Row 14: Capital or Stock Issuance: Provide the amount of cash or cash equivalents an organization receives or uses from Capital or Stock Issuance.
- Row 17: Dividends Paid: Provide the amount of cash or cash equivalents an organization uses for dividend payments to shareholders.
- Row 18: Other Financing Activities: Provide the amount of cash or cash equivalents an organization receives or uses for other financing activities.
- Row 19: NET CASH PROVIDED (USED) BY FINANCING ACTIVITIES: Provide the amount of cash or cash equivalents an organization receives or uses to pay ongoing financing activities.
- Row 20: NET CASH INCREASE (DECREASE) IN CASH: The sum of the change in cash or cash equivalents the organization experienced during the reporting period.

Reconciliation of Net Income to Net Cash Provided by Operating Activities

- Row 23: Provide the excess or deficiency of total revenues over total expenses.

Adjustments to Reconcile Net Income to Net Cash Provided by Operating Activities

- Row 24: Depreciation and Amortization: Adjust depreciation and amortization (non-cash expenses) from net income to determine net cash provided by operating activities.
- Row 25: Decrease (Increase) In Receivables: Adjust changes in receivables from net income to determine net cash provided by operating activities.

- Row 26: Decrease (Increase) In Prepaid Expenses: Adjust changes in prepaid expenses from net income to determine net cash provided by operating activities.
- Row 27: Decrease (Increase) In Affiliated Receivables: Adjust changes in affiliated receivables from net income to determine net cash provided by operating activities.
- Row 28: Decrease (Increase) In Accounts Payable: Adjust changes in accounts payable from net income to determine net cash provided by operating activities.
- Row 29: Decrease (Increase) In Claims Payable and Shared Risk Pool: Adjust changes in claims payable and shared risk pool from net income to determine net cash provided by operating activities.
- Row 30: Decrease (Increase) In Unearned Capitation: Adjust changes in unearned capitation from net income to determine net cash provided by operating activities.
- Row 31: Decrease (Increase) In Other Adjustments to Net Income: Use to determine any other adjustments to net income needed to reconcile to net cash provided by operating activities.
- Row 32: TOTAL ADJUSTMENTS: Provide the sum of all adjustments to Net Income listed in lines 24-31.

Page 6. Projected Financial Grading Criteria

- Row 1: Tangible Net Equity: Attest to how the organization will reach positive TNE as defined in section 1300.76(c).
- Row 2: Required Tangible Net Equity: Determine the minimum TNE requirement for the period, as determined in Schedule I.
- Row 3: Working Capital: Attest to how the organization will reach positive working capital pursuant to section 1300.75.4.2(b)(4).
- Row 4: Cash-to-Claims Ratio: Attest how the organization will reach positive cash-to-claims ratio pursuant to section 1300.75.4.2(b)(5).
- Row 5: Claims Timeliness Percentage: Attest to how the organization will become compliant with claims payment requirements pursuant to section 1300.75.4.2(b)(2).

- Row 6: IBNR Methodology Both Documented and Used in Estimation of IBNR Liabilities: Indicate (yes/no) whether the organization documented and used estimation of IBNR liabilities pursuant to section 1300.77.2.

**General Information for the DMHC Quarterly Financial
Survey Report Form**

Page 2. Balance Sheet: Current Assets. Below is general information for the purposes of filling out this section of the form.¹

List assets available to the RBO during the current period as follows:

- Line 1: Cash and Cash Equivalents (Schedule A): report cash or cash equivalents held in the bank or on hand.
- Line 2: Short-term investments: provide readily saleable investments acquired with temporarily unneeded cash. The collection of securities held by the organization, including Treasury Bills, Commercial Paper, Bankers' Acceptances, Term Deposits, Guaranteed Investment Certificates, and other short-term debt instruments, with less than one year to maturity.
- Line 3: HMO Capitation Receivable-Net (collectible within 30 days) (Schedule B): Provide gross amounts collectible from Health Maintenance Organizations (HMOs) through a capitated or fixed periodic payment, less the amount accrued for receivables, including withholds, refunds, and capitation, determined to be uncollectible during the 60-day period.
- Line 4: HMO Capitation Receivable-Net (collectible beyond 30 days) (Schedule B): Provide gross amounts collectible from HMOs, less the amount accrued for receivables determined to be uncollectible during the period. Include receivables from HMO, such as withholds, refunds, and capitation, but do not include risk receivables.
- Line 5: Non-HMO/Fee-for-Service Receivable – Net (Schedule B): Provide billings for patient care provided directly by the organization and due from third parties or patients, less the amounts accrued for receivables determined to be uncollected during the period.
- Line 8: Risk Pool Receivable – Net (Schedule B): Provide amounts expected to be collected within the fiscal year, under any risk pool arrangement, less the amount accrued for receivables determined to be uncollectible during the period.

¹ Please note the general information documents only include those items where additional description may assist the party filling out the form. Therefore, not all portions of the form are described in the general information document.

- Line 9: Other Incentive Program Receivables – Net (Schedule B): Provide amounts collectible for the reporting organization's incentive receivables, less the amount accrued for receivables determined to be uncollectible during the period.
- Line 10: Secured Affiliate Receivable - Net (Schedule B): Provide amounts of secured current accounts receivable from parent, subsidiary, and/or affiliates. For Department reporting, "Secured Affiliate Receivable" is the obligation that is fully secured by tangible collateral, other than by securities of the plan or the affiliate, with equity of at least 110 percent of the amount owing.
- Line 12: Other Receivable-Net (Schedule B): Provide gross amounts expected to be collected from other sources not previously disclosed, less amounts accrued for receivables determined to be uncollectible for the period.
- Line 13: Other Current Assets: Provide other current assets including prepayments, supply inventories and other items that are not included in the current asset categories.
- Line 14: Total Current Assets: Provide the total of the above listed categories in lines 1-14.

Page 2. Balance Sheet: Other Assets. Below is general information for the purposes of filling out this section of the form.

Lines 15 through 24 account for other assets not listed in Lines 1 through 14.

- Line 15: Long-term Investments: Provide investments intended to be held for a period longer than twelve months.
- Line 16: Intangible Assets and Goodwill-Net: Provide assets of no physical substance.
- Line 17: Risk Pool Receivable (Non-Current) (Schedule B): Provide amounts that will not materialize within the fiscal year less the amount accrued for receivables determined to be uncollectible during the period.
- Line 18: Other Incentive Program Receivables (Non-Current) (Schedule B): Provide amounts collectible for the organization's incentive receivables, net of bad debt allowances.
- Line 19: Secured Affiliate Receivables - Long-Term (Schedule B): Provide are any secured non-current (over 365 days) accounts receivable from a parent, subsidiary and/or affiliates.

- Line 20: Unsecured Affiliate Receivables – Long-Term (Schedule B): Provide any unsecured non-current accounts receivable that is past due from parent, subsidiary and/or affiliate.
- Line 21: Other Non-Current Assets: Provide other non-current assets not reported in previous categories. If the total of this line is more than 15% of all non-current assets reported on lines 14-20, the itemization for this line item must include the details (description and amount).
- Line 24: Total Assets: Provide the total of lines 14, 22, and 24.

Page 2. Balance Sheet: Current Liabilities. Below is general information for the purposes of filling out this section of the form.

Lines 25-34 list the RBOs current liabilities.

- Line 25: Trade Accounts Payable: Provide the amounts due to creditors for the acquisition of goods and services, including trade and vendors rather than health care providers, on a credit basis.
- Line 26: Sub-Capitation Payable: Provide the amounts due to capitated providers (i.e. physicians, medical groups/IPAs, etc.) for medical services rendered to enrollees of the organization.
- Line 29: Withhold/Surplus Payable: Provide amounts accrued, typically as withholds from fee-for-service, sub-capitation payments, risk pool surplus, or bonuses expected to be paid to contracted physicians.
- Line 33: Other Current Liabilities: Provide all other current liabilities. Include all items that are not included in the current liability categories. If the total of this line is more than 15% of all current liabilities reported on Lines 24-32, the itemization for this line item must include the details (description and amount).
- Line 34: Total Current Liabilities: Provide the total of the liabilities listed in Lines 25-34.

Page 2. Balance Sheet: Other Liabilities. Below is general information for the purposes of filling out this section of the form.

In Lines 35-41, provide other liabilities of the RBO not previously listed for the current period.

- Line 35: Loans and Notes Payable (not subordinated) (Long-Term): Provide the principal amount due on loans and notes signed by the organization, not including the current portion payable.
- Line 36: Loans and Notes Payable (subordinated): Provide the principal amount due on loans and notes that are subordinated, including the current portion.
- Line 39: Other Long-Term Liabilities: Provide all other long-term liabilities that are not included above. If the total of this line is more than 15% of all other liabilities reported on Lines 35-39, the itemization for this line item must include the details (description and amount).
- Line 40: Total Other Liabilities: Provide the total of the liabilities listed in Lines 35 – 39.

Page 3. Balance Sheet: Net Worth. Below is general information for the purposes of filling out this section of the form.

In Lines 42-47, provide information regarding the RBOs net worth.

- Line 43: Additional Paid-In Capital: Provide the excess amount of capital contributions for the period (including paid-in capital over stock par or stated value).
- Line 44: Retained Earnings (deficit/fund balance): Provide the cumulative earnings or deficit from operations, net of reserves and restricted funds.
- Line 46: Total Net Worth: Provide the total of Net Worth Categories in lines 43-45.
- Line 47: Total Liabilities and Net Worth: Provide the total of Total Liabilities and Net Worth (line 41 and line 46).

Page 3. Statement of Net Worth- Current Period. Below is general information for the purposes of filling out this section of the form.

In Lines 1-10, please provide additional details regarding Net Worth.

- Line 1: Net Worth Beginning of Period: Provide the starting value carried over from the previous fiscal year.
- Line 2: Audit Adjustments: Provide any adjustments to the above reported net worth that occurred as a result of an audit.

- Line 4: Increase (Decrease) in Additional Paid-In Capital: Provide any additional capital paid-in to the organization, if any, or any loss of capital paid-in to the organization.
- Line 5: Increase (Decrease) in Contributed Capital: Provide any capital contributed or lost to the organization during that period, if any.
- Line 8: Distributions to Shareholders: Provide the value of any distributions to shareholders that occurred during that period and, therefore, reduce the assets available to the organization.
- Line 9: Changes in Other Net Worth Items: Provide any other changes to the net worth of the RBO during the period.

Page 3. Income Statement- Revenues. Below is general information for the purposes of filling out this section of the form.

In Lines 1-6, please provide revenue information.

- Line 1: HMO Revenue: Provide revenue received from HMOs including withholds, refunds, insurance services, capitation, co-payments that are received on an ongoing basis.
- Line 2: Non-HMO/Fee-for-Service Revenue: Provide fee-for-service revenue including Preferred Provider Organization, Health Savings Account, and cash payments, net of contractual and bad debt allowances.
- Line 3: Risk Pool Revenue (Schedule D): Provide revenue earned from risk-sharing contracts. The reporting entity may have contracts that contain certain shared-risk provisions whereby the organization can earn additional incentive revenue based upon the utilization of services by the reporting entity's enrollees.
- Line 6: Total Revenue: Provide the sum of all revenue categories in lines 1-5.

Page 3. Income Statements- Expenses. Below is general information for the purposes of filling out this section of the form.

In Lines 7-16, please provide information regarding the RBOs expenses.

- Line 7: Physician and Physician Extender-Salary & Benefits: Provide the salary and benefit cost of all physician and physician- extenders, which includes optometrists, chiropractors, doctors of osteopathy, nurse practitioners and physician assistants.

- Line 8: Medical Claims Expense: Provide all fee-for-service claim expenses for contracted and non-contracted providers whether actually paid, accrued or calculated in the IBNR estimate, disclosed in the Balance Sheet above.
- Line 12: Administration and Other Expenses (Schedule E): Include all administrative and other expenses not listed in the lines above including administrative services compensation and fringe benefits, interest expenses, occupancy, depreciation/amortization, management fees, marketing, bonuses, and income taxes.
- Line 13: Total Expenses: Provide the sum of the expenses listed in lines 7 – 12.
- Line 14: Income (Loss) Before Provision for Income Taxes: Provide the earnings or loss before taxes, expressed as line 6 minus line 13.
- Line 15: Income Taxes: Provide an estimate of taxes levied by the government on income for the organization.
- Line 16: Net Income (Loss): Provide the earnings after all expenses and taxes have been deducted.

Page 4. Statements of Cash Flow. Below is general information for the purposes of filling out this section of the form.

Statement of Cash Flows for Current Period- Please use this section to demonstrate the changes in cash flow as classified by operating, investing, and financing activities including reconciliation and adjustments to net cash provided by operating activities.

CASH FLOW PROVIDED (USED) BY OPERATING ACTIVITIES

- Line 1: Capitation Revenues: Provide the amount of cash or cash equivalents an organization receives from HMOs.
- Line 2: Fee-for-Service Revenues: Provide the amount of cash or cash equivalents an organization receives on a Fee-for Service basis.
- Line 3: Risk and Incentive Revenues: Provide the amount of cash or cash equivalents an organization receives from risk-sharing and incentive contracts.
- Line 4: Other Revenues: Provide the amount of cash or cash equivalents an organization receives from other revenue sources.

- Line 5: Medical Expenses: Provide the amount of cash or cash equivalents an organization uses to pay medical expenses.
- Line 6: Administrative Expenses and Other Expenses: Provide the amount of cash or cash equivalents an organization uses to pay administrative expenses.
- Line 9: NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES: Provide the amount of cash or cash equivalents an organization receives or uses to pay ongoing operating expenses.

CASH FLOW PROVIDED (USED) BY INVESTING ACTIVITIES

- Line 10: Investments: Provide the amount of cash or cash equivalents an organization receives or uses from the purchase or sale of Investments (non-Trading).
- Line 12: Other Long-Term Assets: Provide the amount of cash or cash equivalents an organization receives or uses from the purchase or sale of Other Long-Term Assets.
- Line 13: NET CASH PROVIDED (USED) BY INVESTING ACTIVITIES: Provide the amount of cash or cash equivalents an organization receives or uses to pay ongoing investing activities.

CASH FLOW PROVIDED (USED) BY FINANCING ACTIVITIES

- Row 17: Dividends Paid: Provide the amount of cash or cash equivalents an organization uses for dividend payments to shareholders.
- Line 18: Other Financing Activities: Provide the amount of cash or cash equivalents an organization receives or uses for Other Financing Activities.
- Line 19: NET CASH PROVIDED (USED) BY FINANCING ACTIVITIES: Provide the amount of cash or cash equivalents an organization receives or uses to pay ongoing financing activities.
- Line 20: NET CASH INCREASE (DECREASE) IN CASH: the sum of the change in cash or cash equivalents the organization experienced during the reporting period.

RECONCILIATION OF NET INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES

- Line 23: Net Income. Provide the excess or deficiency of total revenues over total expenses.

ADJUSTMENTS TO RECONCILE NET INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES

- Line 24: Depreciation and Amortization: Adjust depreciation and amortization (non-cash expenses) from net income to determine net cash provided by operating activities.
- Line 25: Decrease (Increase) In Receivables: Adjust changes in receivables from net income to determine net cash provided by operating activities.
- Line 26: Decrease (Increase) In Prepaid Expenses: Adjust changes in prepaid expenses from net income to determine net cash provided by operating activities.
- Line 27: Decrease (Increase) In Affiliated Receivables: Adjust changes in affiliated receivables from net income to determine net cash provided by operating activities.
- Line 28: Decrease (Increase) In Accounts Payable: Adjust changes in accounts payable from net income to determine net cash provided by operating activities.
- Line 29: Decrease (Increase) In Claims Payable and Shared Risk Pool: Adjust changes in claims payable and shared risk pool from net income to determine net cash provided by operating activities.
- Line 30: Decrease (Increase) In Unearned Capitation: Adjust changes in unearned capitation from net income to determine net cash provided by operating activities.
- Line 31: Decrease (Increase) In Other Adjustments to Net Income: Use to determine any other adjustments to net income needed to reconcile to net cash provided by operating activities.
- Line 32: TOTAL ADJUSTMENTS: Provide the sum of all adjustments to Net Income listed in lines 24-31.
- Line 33: NET CASH PROVIDED BY OPERATING ACTIVITIES: Provide the amount of cash or cash equivalents an organization receives or uses to pay ongoing operating expenses.

Page 5. Grading Criteria. Below is general information for the purposes of filling out this section of the form.

Please use the following Grading Criteria to demonstrate compliance with the DMHC solvency regulations.

Tangible Net Equity- Please self-attest whether positive TNE was maintained during the reporting period, pursuant to section 1300.75.4.2, subdivision (b)(4).

- Line 1: Net Equity: Provide the financial information taken from Line 45 of the Balance Sheet-Net Worth.
- Line 2: Add Subordinated Debt: Provide the information from Line 35 of the Balance Sheet-Other Liabilities.
- Line 3: Less Receivables from officers, directors and affiliates: Provide the information from Lines 10 (Current Assets) and 19 (Other Assets) of the Balance Sheet.
- Line 4: Less Intangibles: Provide the information from Line 15 (Other Assets) of the Balance Sheet.
- Line 5: Tangible Net Equity: Provide the amount calculated from Lines 1-4 directly above.
- Line 6: Required Tangible Net Equity (Schedule I): Provide required TNE, by using Schedule I.
- Line 7: Please state whether the RBO had a positive TNE excess or deficiency.
- Line 8: Maintained a positive TNE at all times, for the reporting period: State "Yes" or "No" if compliant with the TNE requirement at all times during the reporting period.

Working Capital- Please self-attest as to whether the Working Capital requirements were maintained pursuant to the solvency regulations section 1300.75.4.2(b)(4).

- Line 9: Maintained a positive working capital at all times, for the reporting period: State "Yes" or "No" if compliant with the working capital requirement at all times during the reporting period.
- Line 10: Provide working capital calculation.

Cash-to-Claims Ratio

- Line 11: State "Yes" or "No" if compliant with the cash-to-claims ratio at all times during the reporting period.
- Line 12: Provide cash-to-claims calculation.

Claims and IBNR- Please self-attest to the timeframe in which the RBO paid claims and the methodology for calculating IBNR pursuant to 1300.75.4.2(b)(2).

- Line 13: State "Yes" or "No" if compliant with the claims timeliness requirement.
- Line 14: Enter compliance percentage for claims timeliness.
- Line 15: Provide the methodology for calculating IBNR. Examples are lag study, actuarial, estimation or other.
- Line 17: State "Yes" or "No" if the RBO estimated and documented its liability for IBNR claims pursuant to a method specified in section 1300.77.2.
- Line 18: State "Yes" or "No" if the IBNR estimates are the basis for the financial report statement submission.

Pages 6 - 16. Schedules A through Schedule J. Below is general information for the purposes of filling out this section of the form.

- Schedule A- Enter details from the Balance Sheet, Line 1.
- Schedule B- Provide the requested information regarding receivables that were reported in the Balance Sheet.
- Schedule C- Provide an explanation for the method of calculating the provision for Incurred But Not Reported Claims- IBNR.
- Schedule D- Provide the information reported in the Balance Sheet- Income Statement for risk pool and other incentive revenues, Lines 3 and 4.
- Schedule E- Provide the information for administration and other expenses reported in Balance Sheet- Income Statement- Line 12.
- Schedule F- Provide the total enrollment, by product (commercial, Medicare Advantage, Medi-Cal) for which the organization is responsible for health care services provided.

- Schedule G- Provide information regarding the inventory (inflows and outflows) of claims processed on a monthly basis.
- Schedule H- List any mergers, acquisitions or discontinued operations during the reporting period.
- Schedule I- Provide the Tangible Net Equity Requirement
 - Item A: HEALTHCARE REVENUES is the calculation used to determine the required TNE threshold, as determined by annualized healthcare revenues. Annualized healthcare revenues are the summation of HMO Revenues (Line 1), Risk Pool Revenues (Line 3) and Other Incentive Pool Revenues (Line 4) of the Income Statement. Healthcare revenues are annualized from the most recent four quarter period. Schedule I requires the calculation of 1% of annualized healthcare revenues.
 - Item B: HEALTHCARE EXPENDITURES is the calculation used to report the non-capitated medical expenses. Healthcare expenditures are the summation of Medical Claims Expense (Line 8), Pharmacy Expense (Line 9), and Other Medical Expenses (Non-Capitated) (Line 11) of the Income Statement. Healthcare expenditures are annualized from the most recent four quarter period. Schedule I requires the calculation of "4% of annualized healthcare expenditures."
 - Required TNE is the greater of healthcare revenues or healthcare expenditures, as calculated above.
 - TNE Calculation of Annualized Healthcare Revenues and Expenditures is the annualized healthcare revenues and annualized healthcare expenditures on a quarterly and annualized basis.
- Schedule J- Provide any additional notes to Financial Statements used by the RBO.

