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## § 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 other 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 plan receivables due within 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.

(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.

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(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" for purposes of this section, 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, 2004,~~ within ~~40~~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, 2004,~~ within ~~40~~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 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~~

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~~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, 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, d~~ 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 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: ~~4(A)~~ 1 the total number of member months; ~~2(B)~~ 2 ~~The~~ total budget allocation for the member months; ~~3(C)~~ 3 ~~The~~ total expenses paid during the period; ~~4(D)~~ 4 ~~a~~ description of the incurred but not reported (IBNR) claims methodology used for incurred expenses during the period; and ~~5(E)~~ 5 ~~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 150 days and payment no later than 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, effective on or after January 1, 2019, 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

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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, for contracts effective on or after January 1, 2019, between a sub-delegating organization and an organization, shall require the plan or the sub-delegating organization to disclose, on or before October 1, 2004, 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~~ Effective one year from the operative date of this amended section, maintain at all times a minimum "cash-to-claims ratio," as defined in section 1300.75.4(f), of 0.60 0.75. During the one (1) year phase-in period, an organization shall comply with the cash-to-claims ratio definition as required by the Department the year immediately prior to the effective date of this amended section, 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, as incorporated herein by reference, dated May, 2018 and published by the Department on its webpage: [www.dmhc.ca.gov](http://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:

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~~(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 financial survey report information (including 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 the last day of the quarter being reported.~~

~~(B) Quarterly ~~financial~~ 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.~~

~~(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~~

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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 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 or 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.

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

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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").

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, as incorporated herein by reference, dated May, 2018 and published by the Department on its webpage: [www.dmhc.ca.gov](http://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 California Code of Regulations, and shall be based upon the organization's annual audited financial statement prepared in accordance with generally accepted auditing standards principles (GAAP). The annual financial survey report shall contain and containing all of the following:

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~~(1)~~(2) Annual financial survey report, based upon the organization's annual audited financial statements (including at least 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 and 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 any and 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.

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

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

(ii) ~~(B)~~Aan 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)~~4.~~ 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

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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) ~~To~~ estimate and document, on a monthly basis, its liability for IBNR claims; or  
(B) ~~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 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:

1. ~~(i)~~ its audited annual financial statements within 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 or 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.

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

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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, a 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.

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(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.

1<sup>st</sup> Comment Period – Changes to text are noted by underline and ~~strikeout~~

2<sup>nd</sup> Comment Period – Changes to the text are noted by double underline and double ~~strikeout~~

Changes to the forms are noted by double underline and single ~~strikeout~~

(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 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 t~~ 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 t~~ The plan or sub-delegating organization shall advise the Department and the organization in writing within five (5) days of becoming aware: 1. that a contracting organization is not in compliance with the requirements of a final CAP, or 2. that an

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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 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 has the discretion to disapprove, postpone or suspend the sub-delegating organization's proposed transfer of enrollees.

(78) Notwithstanding subsection (6) and (7) of this section, nothing in these regulations shall limit or impair 1. 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. an enrollee's right to self-select a new provider; or 3. 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 effective January 1, 2019, 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 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

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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, effective January 1, 2019, a sub-delegating organization and an organization shall:

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

(A) Obtain and evaluate supplemental financial information pertaining to the organization when: 1. the organization fails to satisfactorily demonstrate its compliance with the Grading Criteria; 2. the organization experiences an event that materially alters its ability to remain compliant with the Grading Criteria; 3. 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. 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.

Effective January 1, 2019, Eevery 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).

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(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](http://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 12 months;~~

~~(B) Timetables specified in the self-initiated CAP for correcting tangible net equity (TNE) deficiencies shall not exceed 12 months;~~

~~(C) Timetables specified in the self-initiated CAP for incurred but not reported (IBNR) deficiencies shall not exceed three (3) months;~~

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(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 45 7 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) 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 10 calendar days to:

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(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)~~ 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)~~ 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)~~ 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)~~ 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)~~ 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~~)(1) of Title 28 of the California Code of Regulations.

(l) CAP Reporting:

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(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 of the first \$150 million of annualized premium revenues plus one percent of annualized premium revenues in excess of \$150 million; or

(3) an amount equal to the sum of:

(A) eight percent 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 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 of annualized hospital expenditures paid on a managed hospital payment basis.

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(b) Each plan licensed pursuant to the provisions of the 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 of the first \$7,500,000 of annualized premium revenues plus one percent of annualized premium revenues in excess of \$7,500,000; or

(3) an amount equal to the sum of:

(A) eight percent 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 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 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 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 110 percent of the amount owing.

(1) Effective one-year after the operative date of this amended section, for the purposes of this section, “positive tangible net equity” that 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 ~~to~~of an organization shall not include the receivables of an affiliate, except those arising in the normal course of business that are payable on the same terms as equivalent transactions with non-affiliates and that are not more than 60 days past due, with which the organization has a risk arrangement.

(3) During the one-year phase in time period, an organization shall comply with the tangible net equity requirements as required by the Department during the year immediately preceding the effective date of the revised TNE amount.

(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.

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(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.

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 Audit Firm

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

10 Reinsurance and Professional Stop-Loss

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

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

Statement of Organization (description of structure)

**Statement of Organization -Detail**

12	RBO Model	
13	Legal Ownership	
14	RBO Ownership	

**15 MSO Information**

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

**16 Dispute Resolution Mechanism Contact**

Address	
City, State, Zip	
Phone	
Website	

**17 Counties Served by the RBO**

--

**18 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	

**19 Affiliate Information**

Affiliate Business Name	
Affiliate Address	
City, State, Zip	



<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	

**Balance Sheet**

<b>Current Assets</b>		<b>Current Period</b>
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	<b>Total Current Assets</b>	
<b>Other Assets</b>		
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	<b>Total Other Assets</b>	
23	<b>Total Property and Equipment-Net</b>	
24	<b>Total Assets</b>	
<b>Current Liabilities</b>		
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	<b>Total Current Liabilities</b>	
<b>Other Liabilities</b>		
35	Loans and Notes Payable (not subordinated) (Long-Term)	
36	Loans and Notes Payable (subordinated)	

37 36	Accrued Subordinated Interest Payable	
38 37	Amounts Due to Affiliates (Long-Term)	
39 38	Other Long-Term Liabilities	
40 39	Total Other Liabilities	
41 40	Total Liabilities	
	<b>Net Worth</b>	
42 41	Capital	
43 42	Additional Paid-In Capital	
44 43	Retained Earnings (deficit/fund balance)	
45 44	Other Net Worth Items	
46 45	Total Net Worth	
47 46	Total Liabilities and Net Worth	

<b>Statement of Net Worth</b>		<b>Current Period</b>
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	

<b>Income Statement</b>		<b>Year-To-Date</b>
<b>Revenues</b>		
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	
<b>Expenses</b>		
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)	

**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	<b>NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES</b>	

**CASH FLOW PROVIDED (USED) BY INVESTING ACTIVITIES**

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

**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	<b>NET CASH PROVIDED (USED) BY FINANCING ACTIVITIES</b>	
20	<b>NET CASH INCREASE (DECREASE) IN CASH</b>	
21	<b>CASH AND CASH EQUIVALENTS AT BEGINNING OF THE YEAR</b>	
22	<b>CASH AND CASH EQUIVALENTS AT END OF THE YEAR</b>	

**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	<b>TOTAL ADJUSTMENTS</b>	
33	<b>NET CASH PROVIDED BY OPERATING ACTIVITIES</b>	

**Grading Criteria**

**Tangible Net Equity**

**Current Period**

<u>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>8.7</u>	Maintained a positive Tangible Net Equity (TNE) at all times, for the reporting period	

**Working Capital**

<u>9.8</u>	Maintained a positive working capital at all times, for the reporting period	
<u>10-9</u>	Working capital must be calculated based on financial information at the last day of the reporting period	

**Cash-to-Claims Ratio**

<u>11.40</u>	Maintained the required cash-to-claims ratio, at all times, for the reporting period (section 1300.75.4.2 (c)(4))	
<u>12.41</u>	Ratio must be based on financial information at the last day of the reporting period	

**Claims and IBNR**

<u>13.42</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>14.43</u>	Enter percentage	
<u>15.44</u>	Methodology for Calculating IBNR	
<u>16.45</u>	If other, describe the methodology of calculating IBNR	
<u>17.46</u>	Has the RBO estimated and documented, on a monthly basis, its liability for IBNR claims?	
<u>18.47</u>	Are IBNR estimates the basis for the financial statement submission?	

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>
	<b><u>Total of all balances* =</u></b>		

\*should agree with Balance Sheet, Row 1

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)	<del>3-60</del> 3 1-30 Days	4 31-60 Days	<del>5-30</del> 5 61-90 Days	<del>6-40</del> 6 Over 90 Days	<del>7-50</del> 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	<u>Total - Individual Listed Receivables</u>				0	*		0	0
34	<u>Aggregate Accounts Not Individually Listed</u>				0			0	0

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.

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>

Schedule E

**Administration and Other Expenses**

<b><u>Expenses</u></b>	<b><u>Year-To-Date</u></b>
<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>	
<b><u>Total</u></b>	

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>
<b>Total Enrollment</b>				

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>					



**REQUIRED TANGIBLE NET EQUITY (TNE) CALCULATION**

**TNE required must be equal to the Greater of "A", or "B" or "C"**

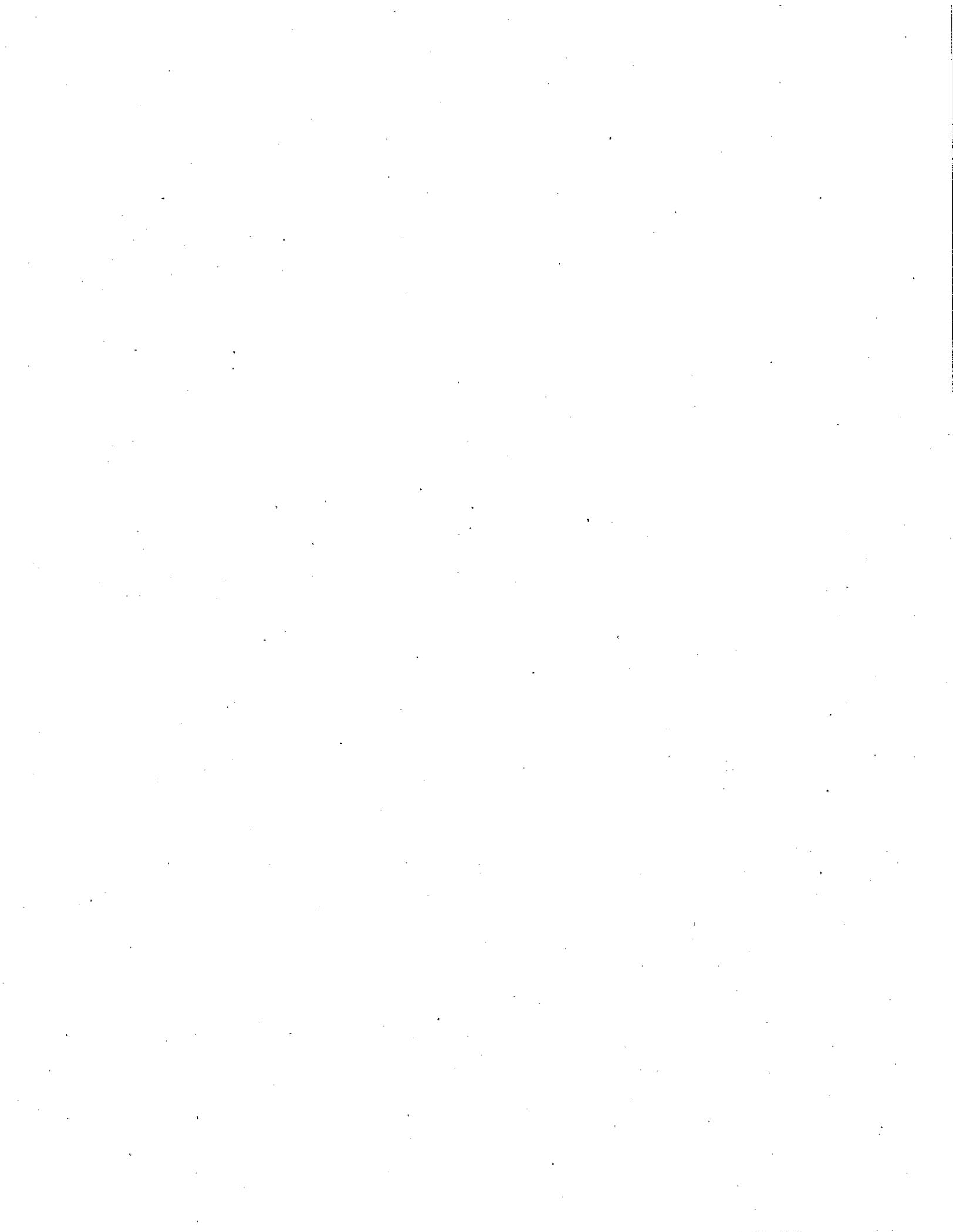
		Current Period
<b>A.</b>	<b>Minimum TNE Requirement</b>	
<b>B.</b>	<b>A. HEALTHCARE REVENUES</b>	
	1% of annualized healthcare revenues	
<b>C.</b>	<b>B. HEALTHCARE EXPENDITURES</b>	
	4% of annualized healthcare expenditures	
	Required "TNE" - Greater of "A", or "B" or "C"	

**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					

Schedule J

**Notes to Financial Statements**



RBO Details

1	RBO	
2	Created By	
3	Date Created	
4	Date Completed	
5	Combining Schedules	
6	Report Status	

7 Notes\Combining Schedules\Annual Audit Report Upload  
(Document attached) - as needed.

**Balance Sheet**

<b>Current Assets</b>		<b>Current Period</b>
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	<b>Total Current Assets</b>	
<b>Other Assets</b>		
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	<b>Total Other Assets</b>	
23	<b>Total Property and Equipment-Net</b>	
24	<b>Total Assets</b>	
<b>Current Liabilities</b>		
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	<b>Total Current Liabilities</b>	
<b>Other Liabilities</b>		
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	<b>Total Other Liabilities</b>	
41	<b>Total Liabilities</b>	

	<b>Net Worth</b>	
42 41	Capital	
43 42	Additional Paid-In Capital	
44 43	Retained Earnings (deficit/fund balance)	
45 44	Other Net Worth Items	
46 45	Total Net Worth	
47 46	Total Liabilities and Net Worth	

	<b>Statement of Net Worth</b>	<b>Current Period</b>
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	

	<b>Income Statement</b>		
	<b>Revenues</b>	<b>Current Period</b>	<b>Year-To-Date</b>
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		
	<b>Expenses</b>		
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)		

**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	<b>NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES</b>	

**CASH FLOW PROVIDED (USED) BY INVESTING ACTIVITIES**

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

**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	<b>NET CASH PROVIDED (USED) BY FINANCING ACTIVITIES</b>	
20	<b>NET CASH INCREASE (DECREASE) IN CASH</b>	
21	<b>CASH AND CASH EQUIVALENTS AT BEGINNING OF THE QUARTER</b>	
22	<b>CASH AND CASH EQUIVALENTS AT END OF THE QUARTER</b>	

**RECONCILIATION OF NET INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES**

23	Net Income	
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**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	<b>TOTAL ADJUSTMENTS</b>	
33	<b>NET CASH PROVIDED BY OPERATING ACTIVITIES</b>	

## Grading Criteria

<b>Tangible Net Equity</b>		<b>Current Period</b>
<u>1</u>	<u>Net Equity</u>	
<u>2</u>	<u>Add Subordinated Debt</u>	
<u>3</u>	<u>Less Receivables from officers, directors and affiliates</u>	
<u>4</u>	<u>Less Intangibles</u>	
<u>5</u>	<u>Tangible Net Equity</u>	
<u>6</u>	<u>Required Tangible Net Equity (Schedule I)</u>	
<u>7</u>	<u>Tangible Net Equity Excess (Deficiency)</u>	
<u>8.7</u>	<u>Maintained a positive Tangible Net Equity <del>TNE</del> at all times, for the reporting period</u>	

## **Working Capital**

<u>9.8</u>	<u>Maintained a positive working capital at all times, for the reporting period</u>	
<u>10.9</u>	<u>Working capital must be calculated based on financial information at the last day of the reporting period</u>	

## **Cash-to-Claims Ratio**

<u>11.40</u>	<u>Maintained the required cash-to-claims ratio, at all times, for the reporting period (section 1300.75.4.2 (b)(5))</u>	
<u>12.41</u>	<u>Ratio must be based on financial information at the last day of the reporting period</u>	

## **Claims and IBNR**

<u>13.42</u>	<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>	
<u>14.43</u>	<u>Enter percentage</u>	
<u>15.44</u>	<u>Methodology for Calculating IBNR</u>	
<u>16.45</u>	<u>If other, describe the methodology of calculating IBNR</u>	
<u>17.46</u>	<u>Has the RBO estimated and documented, on a monthly basis, its liability for IBNR claims?</u>	
<u>18.47</u>	<u>Are IBNR estimates the basis for the financial statement submission?</u>	



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	0



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.

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>

Schedule E

**Administration and Other Expenses**

<b>Expenses</b>	<b>Current Period</b>	<b>Year-To-Date</b>
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		
<b>Total</b>		

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>
<b>Total Enrollment</b>				

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>					



Schedule I

**REQUIRED TANGIBLE NET EQUITY (TNE) CALCULATION**

**TNE required must be equal to the Greater of "A", or "B" or "C"**

		Current Period
<b>A.</b>	<b>Minimum TNE Requirement</b>	
<b>B.</b>	<b>A. HEALTHCARE REVENUES</b>	
	1% of annualized healthcare revenues	
<b>C.</b>	<b>B. HEALTHCARE EXPENDITURES</b>	
	4% of annualized healthcare expenditures	
	Required "TNE" - Greater of "A", or "B" or "C"	

**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					

Schedule J

**Notes to Financial Statements**