

**DEPARTMENT OF MANAGED HEALTH CARE
TITLE 28, SECTION 1300.75.4,
TITLE 28, SECTION 1300.75.4.1,
TITLE 28, SECTION 1300.75.4.2,
TITLE 28, SECTION 1300.75.4.5,
TITLE 28, SECTION 1300.75.4.7,
TITLE 28, SECTION 1300.75.4.8, AND
TITLE 28, SECTION 1300.76**

(Control No. 2017-5216)

INITIAL STATEMENT OF REASONS

FINANCIAL SOLVENCY OF RISK BEARING ORGANIZATIONS

As required by section 11346.2 of the Government Code, the Director of the Department of Managed Health Care (Director) sets forth below the reasons for the amendment of sections 1300.75.4, 1300.75.4.1, 1300.75.4.2, 1300.75.4.5, 1300.75.4.7, 1300.75.4.8, and 1300.76 to title 28, California Code of Regulations (Regulations).

GENERAL PURPOSE

The Department of Managed Health Care (Department) does not directly regulate risk-bearing organizations (organizations), as defined pursuant to Health and Safety Code section 1375.4, subdivision (g)(1), and section 1300.75.4, subdivision (b) of the Regulations. Rather, the Department's authority with respect to organizations derives from the Department's authority to regulate health care service plan (health plans) contracts with organizations. The Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) gives the Department authority to obtain financial, enrollment, and other information from organizations that contract with licensed health plans or arrange for the provision of health care services of a health plan's enrollees; the Department also has authority to require organizations to meet various financial thresholds to help ensure the organizations have the necessary resources to provide health care services to enrollees and to prevent financial insolvency. The language in Health and Safety Code section 1375.4 of the Knox-Keene Act gives the Department authority to oversee sub-delegated organizations in the same way the Department oversees organizations that contract directly with health plans.

The purpose of the proposed regulatory action is to amend sections 1300.75.4, 1300.75.4.1, 1300.75.4.2, 1300.75.4.5, 1300.75.4.7, 1300.75.4.8, and 1300.76 of title 28, of the Regulations, to implement, interpret and make specific the rights and requirements under Health and Safety Code sections 1375.4. Health and Safety Code section 1375.4 grants the Director authority to adopt rules and regulations to implement a process for reviewing or grading the financial solvency of organizations, clarify the financial information required from organizations to assist in this review, conduct audits, a process for corrective action plans (CAPs) of an organization that has solvency deficiencies, disclosure of relevant information from a health plan to an

organization to enable the organization to be informed regarding the risk assumed under the parties' contract, periodic reports to the Department from health plans and organizations, and the confidentiality of these disclosures.

The proposed amendments and additions will allow the Department to consistently implement the provisions of Health and Safety Code section 1375.4, including clarifying the definition of an organization, how these organizations report financial solvency, and the financial solvency standards that an organization is required to meet. These changes will allow the Department to ensure that organizations are financially capable of taking on the weight of their risk-based agreements to provide health care services to health plan enrollees. Without such oversight, delivery and quality of healthcare for California healthcare consumers could be disrupted and the healthcare marketplace negatively impacted through these types of contractual delegations. Proposed amendments to sections 1300.75.4, 1300.75.4.1, 1300.75.4.2, 1300.75.4.5, 1300.75.4.7, 1300.75.4.8, and 1300.76 build on current regulations to remedy identified inconsistencies, and ambiguities that negatively impact health plan enrollees and the healthcare marketplace.

The Department has also made non-substantive changes to the text including correcting grammar, spelling and making the text plain English.

AUTHORITY

Pursuant to Health and Safety Code section 1341, subdivision (a), the Department "has charge of the execution of the laws of this state relating in to health care service plans... including, but not limited to, those laws directing the department to ensure that health care service plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees."

Health and Safety Code section 1341.9, vests the Department with all duties, powers, purposes, responsibilities, and jurisdiction as they pertain to health plans and health plan business.

Health and Safety Code section 1344 grants the Director authority to adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of the Knox-Keene Act.

Health and Safety Code section 1345, subdivision (f)(1), defines a "health care service plan" as "any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost of those services in return for a prepaid or periodic charge paid by or on behalf of subscribers or enrollees."

Health and Safety Code section 1346, vests in the Director additional powers to administer and enforce the Knox-Keene Act, including but not limited to, the power to study, investigate, research, and analyze matters affecting the interests of plans, subscribers, enrollees, and the public, and to promote and establish standards of ethical conduct for the administration of health care service plans.

Health and Safety Code section 1375.4, requires the Director adopt regulations to implement the required provisions for contracts between a health plan and a risk-bearing organization. Pursuant

to subdivision (b), these regulations shall include a process for reviewing the financial solvency of risk-bearing organizations, a process for CAPs to correct deficiencies, disclosure of enrollment and risk arrangement information from health plans, reports by the health plans to the Director that include information concerning the risk-bearing organizations, and the confidentiality of financial and other records produced, disclosed, or otherwise made available under this section.

Historically, the Department's predecessor, the Department of Corporations, issued limited licenses pursuant to the Knox-Keene Act to some medical provider groups. These licenses allowed groups that entered into arrangements with fully licensed health plans to assume financial risk for the provision of both institutional (hospital) and professional services. Two of the large medical groups holding such limited licenses became insolvent in the 1990s, causing disruption to the delivery of healthcare to enrollees in California. In response to the insolvencies, the legislature passed Senate Bill (SB) 260 (Stats. 1999, ch. 529 (1999-2000 Reg. Sess. §1)) in 1999 to enhance consumer protection for enrollees who receive health care services through risk-bearing contracts between an organization and a health plan.

SB 260 sought to assure the actuarial soundness of all provider groups that assume responsibility for providing health care to enrollees. SB 260 did this by establishing the Financial Solvency Standards Board within the newly created Department¹, and by requiring that a contract between a full service health plan and an organization have provisions concerning the organization's administrative and financial capacity.² SB 260 further required the Director to adopt financial solvency regulations for organizations, and to investigate and take enforcement action against a health plan that failed to comply with the prescribed solvency requirements.³

SPECIFIC PURPOSE/PROBLEM AND NECESSITY THAT THE AMENDMENTS ADDRESS

AMENDMENTS TO TITLE 28, SECTION 1300.75.4

The amendment to section 1300.75.4, subdivision (b), is necessary to clarify that the definition of an organization includes an organization that contracts directly with a health plan as well as organizations that arrange for the health care services of a health plan's enrollees, but do not contract directly with the health plan. This latter category of organizations contracts with another organization (the sub-delegating organization) rather than the health plan to arrange for the health care services of a health plan's enrollees. The Department has seen an increase in the number of organization-to-organization risk-shifting arrangements where a health plan delegates the financial risk of health care for a portion of the health plan's enrollees to an organization through a direct contractual relationship. In turn, that organization then contracts with another organization and delegates to that organization, through a second risk-shifting arrangement, the responsibility for the health care services and financial liability for at least a portion of the health plan's enrollees. These relationships have become problematic because the Department's current regulations do not address the oversight of these sub-delegated organizations. This proposed

¹ Health and Safety Code section 1347.15.

² Health and Safety Code section 1375.4.

³ Health and Safety Code section 1375.4, subdivisions (b) & (c).

amendment seeks to clarify that all organizations, whether they contract directly with a health plan or with another organization for the responsibility for the health care services of a health plan's enrollees shall report to the Department as an organization if they otherwise meet the definition of an organization pursuant to Health and Safety Code section 1375.4, subdivision (g).

The amendment to section 1300.75.4, subdivision (f), is necessary to clarify the accounting procedures used to determine the "cash-to-claims ratio." The original regulation included a list of exclusions that needlessly complicated the section. The amended regulation provides clear direction to organizations on how to calculate the cash-to-claims ratio thereby preventing confusion. Additionally, the reduction in timeframe from 60 days to 30 calendar days is necessary for the Department to determine an organization's ability to pay provider claims. Receivables not due within 30 days are only reasonably anticipated to be paid at a later date and, therefore, do not accurately reflect readily available funds available to the organization to pay claims and remain solvent.

The amendment to section 1300.75.4, subdivision (j), is necessary to define "sponsoring organization." Health and Safety Code section 1375.4, subdivision (b)(1)(B), allows an organization to use a sponsoring organization guarantee so long as 1) the guarantee is board approved by the sponsoring organization; 2) the sponsoring organization agrees to submit audited financial statements to the health plan; 3) the guarantee is unconditional except for the monetary limit; 4) the guarantee is not limited in duration with respect to the liabilities arising during the term of the guarantee; and 5) the sponsoring organization will provide six months advance notice of cancellation. This amendment will ensure that all parties clearly understand their obligations and requirements when receiving a sponsoring organization guarantee.

The amendment to section 1300.75.4, subdivision (k), is necessary to define "sub-delegating organization." Health and Safety Code section 1375.4 applies to both organizations that contract directly with a health plan and those that arrange for the health care services of a health plan's enrollees through a contract with another organization. However, the current regulations are silent regarding the reporting requirements and CAPs that apply to an organization that contract with another organization rather than a health plan. This amendment will ensure that all parties clearly understand their obligations and requirements in such a sub-delegation arrangement.

AMENDMENTS TO TITLE 28, SECTION 1300.75.4.1

The amendment to section 1300.75.4.1, subdivision (a), is necessary to clarify the requirements that a sub-delegating organization shall include the same provisions in their contract with another organization that a health plan is required to include in a contract with an organization. The authority to require that sub-delegating organizations include these contractual provisions stems from the contractual provisions that are required to be included in the contract between a health plan and an organization under the Knox-Keene Act.

The amendment to section 1300.75.4.1, subdivision (a), is necessary to remove outdated and obsolete timeframes in subdivisions (a)(1) through (a)(5) and clarify the current requirements of the regulation. The original subdivisions included outdated and obsolete provisions to phase-in

certain requirements, needlessly complicating the section and potentially causing confusion for health plans, organizations and sub-delegating organizations.

The amendment to section 1300.75.4.1, subdivision (a)(4), is necessary to clarify the types of risk arrangements that shall be disclosed by health plans and sub-delegating organizations as well as update the terms to reflect current usage: Medicare+Choice has been replaced by Medicare Advantage by the Centers for Medicare and Medicaid Services (CMS); “traditional commercial” is not defined, but is generally understood in the industry to mean commercial products including large group, small group, and individual; and “Point of Service” is a product type sold by health plans rather than a market category and, therefore, should be removed. The amendments remove these outdated, undefined, and incorrect terms to increase clarity of the subdivision.

The amendment to section 1300.75.4.1, subdivision (b), is necessary to provide the effective date under which all sub-delegating organizations, as well as health plans, shall disclose, pursuant to the Regulations, the fees paid under any contract and the way those fees are determined. This is essential for the health plans and sub-delegating organizations to understand and create financial projections to maintain their financial solvency and not jeopardize access to health care for health plan enrollees.

The amendment to section 1300.75.4.1, subdivision (b), is necessary to update the Regulations to the language currently used by CMS and other health care payers. Specifically, the RBRVS (Resources-Based Relative Value Scale)⁴ system, which is currently used by CMS to pay physicians, is included in a non-exclusive list including “alternative payment models” to allow the amended regulation to be applied to new CMS and payer payment models.

The amendment to section 1300.75.4.1, subdivision (c), is necessary to provide the effective date under which all sub-delegating organizations, as well as health plans, shall disclose, pursuant to the Regulations, the amount paid per enrollee per month as well as any deductions. This is essential for health plans and sub-delegating organizations to understand and create financial projections to maintain their solvency and not jeopardize a health plan’s enrollees access to health care.

AMENDMENTS TO TITLE 28, SECTION 1300.75.4.2

The amendment to section 1300.75.4.2 is necessary to clarify that an organization-to-organization contract shall include the same requirements as a health plan-to-organization contract, as detailed in the regulation. Additionally, the citations have been updated throughout to correctly update and incorporate the amendments to the regulation.

⁴ The American Medical Association defines Resource-based Relative Value Scale (RBRVS) as a physician payment system utilized by the CMS and other payers that is based on the principle that payments for physician services should vary with the resource costs for providing those services (including physician work, practice expense, and malpractice expense). Under revised CMS payment methods RBRVS continues to be used but on a modified basis.

The amendment to section 1300.75.4.2, subdivision (a), is necessary to clean up outdated timeframe requirements to the regulation. The original subdivision included obsolete provisions and dates that are no longer relevant. Subdivision (a) is also amended to clarify that there is a one-year phase in time period to allow organizations to comply with the revised cash-to-claims ratio definition. This is done to balance the interest of the health plans and organizations while not jeopardizing access to healthcare for health plan enrollees.

The amendment to section 1300.75.4.2, subdivisions (b) and (c), is necessary to clean up an outdated timeframe contained in the regulation. The original subdivisions included obsolete provisions to phase-in certain requirements, needlessly complicating the section. The amendment to section 1300.75.4.2, subdivisions (b) and (c), also incorporate by reference the “DMHC Quarterly Financial Survey Report Form” as dated May, 2018 and the “DMHC Annual Financial Survey Report Form” as dated May, 2018. These forms allow organizations to report the financial information required pursuant to section 1300.75.4.2 on easy to use forms that will allow the Department to analyze the data effectively and efficiently. Organizations have already been using a version of these forms, which have simply been updated and incorporated by reference in the revised regulations.

The removal of section 1300.75.4.2, subdivisions (b)(1) and (b)(2), is necessary to remove the distinction between organizations that serve at least 10,000 covered lives and those that cover more than 10,000 lives. Previously, organizations with less than 10,000 covered lives would simply provide an attestation as to whether they met the solvency criteria. Therefore, the Department would have to wait up to 150 days after the fiscal year end before receiving audited financial data to allow them to adequately determine whether the organization was truly solvent or if they were facing financial issues that could, potentially, disrupt their ability to serve health plan enrollees. Removal of the amount of covered lives distinction will allow the Department to better oversee the organizations’ financial solvency and prevent any disruption to access to healthcare for health plan enrollees that could result from potential insolvency or financial instability of the organization. Additionally, the impact on organizations with less than 10,000 covered lives should be minimal. Currently, these organizations already prepare the required financial statements in order to provide the attestations so providing them to the Department will not increase their accounting burden.

The amendment to section 1300.75.4.2, subdivisions (b)(1) and (c)(1), is necessary to clarify the information that shall be included in the financial survey reports, the *DMHC Quarterly Financial Survey Report Form* and *DMHC Annual Financial Survey Report Form*, discussed in detail below. These financial survey report forms are required to be prepared in accordance with generally accepted accounting principles (GAAP) and assist the Department in reviewing and grading organizations and ensuring financial solvency. Without the detailed reports the Department does not have sufficient information to properly monitor financials to spot deficiencies and correct them before they negatively impact the healthcare marketplace and enrollees.

The addition of section 1300.75.4.2, subdivisions (b)(1)(A) and (c)(1)(A), is necessary to assist the Department in enforcing the financial solvency regulations as they apply to organizations, including those organizations that do not contract directly with health plans. This will prevent

confusion about regulatory compliance amongst the parties to these types of contractual arrangements and clarify the requirements that shall be met under the Regulations.

The amendment to section 1300.75.4.2, subdivisions (b)(1)(B) and (c)(1)(B), is necessary to clarify when a combined financial survey report is required by the Department. The Department has found confusion about when a financial statement of the organization's affiliate⁵ shall be used on a combining basis with an organization. This is a serious concern for the Department because, potentially, financial information vital to the Department's determination of the financial solvency of an organization may not be properly analyzed if this information is not reported. To clarify this requirement, the word "either" has been included to make clear that if either the affiliate or organization is legally or financially responsible for the payment of the organization's financial claims the organization and affiliate shall provide the financial survey report on a combined basis. The Department needs this information to ensure the organization and affiliate who is responsible for paying the financial claims is viable. Where an organization is reliant on the parent (affiliate) for funding or the organization is loaning money to an affiliate, the Department is able to analyze the financial solvency of those affiliates to ensure the viability of such arrangements. Additionally, the amendment allows the Director to have the discretion to allow these reports separately when appropriate on an individual basis.

The amendment to section 1300.75.4.2, subdivisions (b)(1)(C)(i) and (c)(1)(C)(i), is necessary to add "cash-to-claims ratio" to the accounting procedures which a sponsoring organization's⁶ guarantee may be used. This information clarifies the solvency criteria that may be used in a guarantee. Existing subdivision (b)(2) states that an organization may use a guarantee to reduce its liabilities, but existing subdivisions (b)(1)(A) and (c)(3)(A) do not reference cash-to-claims ratio. This amendment will reduce confusion by adding the cash-to-claims ratio to the respective new subdivisions.

The amendment to section 1300.75.4.2, subdivisions (b)(4) and (c)(3), are necessary to clarify that an organization, when calculating working capital, defined as excess of current assets over current liabilities⁷, shall exclude affiliates' receivables except those that are accounted for in the regular course of business. This amendment provides clarity to the calculating methods that shall be used by an organization when preparing their financial report.

The additions of section 1300.75.4.2, subdivisions (b)(4)(A)(ii)a. and (c)(3)(A)(ii)a., are necessary to clarify that an organization may not rely indefinitely on a sponsoring organization to meet its financial requirements under the Solvency Regulations.⁸ Health and Safety Code section 1375.4, subdivision (b)(1)(B), directs the Department to adopt regulations allowing an organization to reduce its liabilities for purposes of calculating TNE and working capital. Additionally, the Knox-Keene Act states that a guarantee is not limited in duration with respect

⁵ Section 1300.45, subdivision (c) of the regulations defines an affiliate as a person controlled by, under common control with, or controlling another person.

⁶ Pursuant to Health and Safety Code section 1375.4, subdivision (b)(1)(B), a sponsoring organization is an organization that maintains a level of TNE sufficient to show that it has the financial reserves to make a qualified guarantee to offset the liabilities of an organization.

⁷ Section 1375.4, subdivision (b)(1)(A)(iv).

⁸ Section 1300.75.4, subdivision (e) of the regulations defines "Solvency Regulations" as sections 1300.75.4 through 1300.75.8 of Title 28 of the California Code of Regulations.

to the liabilities arising during the term of the guarantee. However, “term” was not defined and organizations have relied on sponsoring organizations indefinitely to bolster their financial position without actually maintaining their own solvency. If the sponsoring organization were to withdraw the guarantee, this lack of financial support could lead to an organization becoming insolvent under the requirements of the Solvency Regulations. This weakens the overall intent of these Solvency Regulations and has the potential to disrupt the delivery of healthcare to enrollees. Rather than an indefinite term for a guarantee, the proposed amendments clarify that an organization may use a sponsoring organization for a guarantee term of one fiscal year to determine liability. After the initial year of relying on a sponsoring organization guarantee, an organization may request from the Department an extension of up to one additional year. This provides the Department the means to enforce the financial solvency criteria of organizations, and maintain marketplace stability, while providing organizations flexibility when they need additional funds to demonstrate solvency.

The addition of section 1300.75.4.2, subdivisions (b)(4)(A)(ii)b. and (c)(3)(A)(ii)b., is necessary to clarify when an organization chooses to rely on a sponsoring organization, the organization shall also have a viable plan for how to maintain solvency once the guarantee from the sponsoring organization ends. If the organization is not able to demonstrate projected solvency after the conclusion of the guarantee term, the Department may require a corrective action plan (CAP) to assist the organization in resolving its solvency issues.

The addition of section 1300.75.4.2, subdivisions (b)(4)(A)(ii)c. and (c)(3)(A)(ii)c., is necessary to clarify that if an organization receives permission for an extension of the guarantee from the Director, then the organization shall annually provide the Department projections on how it will become solvent without reliance on the sponsoring organization’s guarantee in the future.

The amendment to section 1300.75.4.2, subdivisions (b)(5) and (c)(4), are necessary to remove obsolete timeframes that needlessly complicated the subdivisions.

The amendment to section 1300.75.4.2, subdivision (e), is necessary to clarify that when a financial survey report is filed pursuant to rule 1300.75.4.2, the report shall be verified by a principal officer attesting the report is true and correct. This provides the Department a contact person to question if issues arise with the report and, potentially, a responsible person if the report contains falsehoods or other incorrect information.

The amendment to section 1300.75.4.2, subdivision (f), is necessary to clarify similar to a health plan, a sub-delegating organization has a duty to alert the Department if it discovers any contracting organization has experienced an event that alters its financial situation or threatens the organization’s financial solvency. This provides the Department with another method of monitoring financial solvency and preventing disruption in health care services to enrollees and potential negative impact to the healthcare marketplace.

AMENDMENTS TO TITLE 28, SECTION 1300.75.4.5

The amendments to section 1300.75.4.5, are necessary to clarify that an organization-to-organization contract shall include the same requirements as a health plan-to-organization

contract, as already listed in the rule. Additionally, the numbering in the regulation has been updated to incorporate the proposed amendments to the regulation.

The amendment to section 1300.75.4.5, subdivision (a)(1), is necessary to clarify to health plans and sub-delegating organizations when they receive any reports and financial information from an organization, even if not specifically required in the regulations, but instead is provided under the contract, the health plan or sub-delegating organization shall review the reports and information to ensure the financial viability of the organization's risk arrangements. This requirement is intended to address situations where a health plan or sub-delegating organization receives documents from an organization that the regulations do not require the organizations to file, such as quarterly financial statements, but the health plan or sub-delegating organization nevertheless receives under contractual requirement. The Department relies on health plans and sub-delegating organizations to review financial information and maintain oversight of its contracted organizations.

In a recent California Supreme Court decision, the Court examined whether a health plan that negligently delegates or fails to de-delegate the financial risk for the health care services of the health plan's enrollees to a provider group (organization) the health plan knows or should have known will not be able to pay non-contracted emergency provider claims can be held liable to such providers.⁹ This case strengthens the duty placed on health plans to closely examine the financial viability of contracted organizations who pay claims on their behalf.

The amendment to section 1300.75.4.5, subdivision (a)(7), is necessary to clarify a sub-delegating organization shall notify the health plan of a pending transfer of enrollees from an organization in a final CAP to ensure the health plan is able to determine whether the Department must be notified.¹⁰ This requirement provides safeguards for an organization that is attempting, through a CAP, to resolve financial deficiencies and maintain solvency. If enrollees were removed and transferred from the organization, it could potentially have a significant negative impact on the financial status of the organization and cause harm to enrollees.

AMENDMENTS TO TITLE 28, SECTION 1300.75.4.7

The amendment to section 1300.75.4.7 is necessary to clarify that an organization-to-organization contract shall include the same requirements as a health plan-to-organization contract, as listed in the rule, to ensure financial viability and prevent disruption to the healthcare marketplace.

AMENDMENTS TO TITLE 28, SECTION 1300.75.4.8

The amendments to section 1300.75.4.8 are necessary to clarify that an organization-to-organization contract shall include the same requirements as a health plan-to-organization contract, as listed in the rule, to ensure financial viability and prevent disruption to the healthcare marketplace. Additionally, the numbers have been updated throughout to incorporate the amendments to the regulation and prevent confusion.

⁹ Centinel Freeman Emergency Medical Associates v. Health Net of California, Inc., (2016) 1 Cal.5th 994.

¹⁰ See section 1300.75.4.5, subdivision (a)(6).

The amendment to section 1300.75.4.8, subdivision (a), is necessary to incorporate by reference the “DMHC Corrective Action Plan (CAP) Form” as dated May, 2018. This form allows organizations to report the financial the information required under 1300.75.4.8 on a form that allows the Department to analyze the data effectively and efficiently.

The removal of old section 1300.75.4.8, subdivision (a)(7), is necessary to remove unnecessary information for a CAP proposal. This amendment removes obsolete provisions that needlessly complicate the subdivision and may cause confusion amongst the parties to the CAP.

The addition of new section 1300.75.4.8, subdivision (a)(7), clarifies when organizations can avoid submitting a self-initiated CAP. This is addition is necessary to streamline and make the CAP process more efficient.

The amendment to section 1300.75.4.8, subdivision (c), is necessary to streamline the CAP finalization process. This amendment reduces the time a health plan or sub-delegating organization has to object to a proposed CAP and enables the CAP decision to be issued by the Department in a timely manner.

The amendment to section 1300.75.4.8, subdivision (d), is also necessary to streamline the CAP finalization process. This amendment redirects the CAP objections from the organization to the Department when reviewing the CAP and decreases the time in which the objections may be made. This allows the proposed CAP to be finalized on an expedited basis when the objections can be addressed without revisions.

The amendment to section 1300.75.4.8, subdivision (e), is necessary to streamline the CAP finalization process. This amendment shortens the timeframe for objections to be filed for the revised CAP proposal and allows the revised CAP proposal to be finalized if no further objections are received during this stage of the Department’s review.

The amendment to section 1300.75.4.8, subdivision (f), is necessary to streamline the CAP finalization process. This amendment reduces the number of days a health plan or sub-delegating organization may object to and reconcile differences on the revised CAP proposal. A shorter timeframe is appropriate because the majority of objections are resolved in the earlier stages of the CAP process.

The amendment to section 1300.75.4.8, subdivision (g), is necessary to make clear that the timeline for the self-initiated CAP proposal is seven (7) calendar days and to clarify that this subdivision is also applicable to the sub-delegating organizations.

The amendment to section 1300.75.4.8, subdivision (h), is necessary to provide the Department’s external body, which reviews final CAP proposals, to reach a determination on the CAP proposal. Additional time is necessary because this process involves a third party. This additional time provides sufficient days for the external party to do a thorough and complete review of the CAP and understand the logistics involved between the parties.

The amendment to section 1300.75.4.8, subdivision (i), is necessary to streamline the CAP finalization process. This amendment reduces the time for the Department to approve, disapprove, or modify the external party's recommendation and issue the final decision in a timely manner to benefit all parties.

The amendment to section 1300.75.4.8, subdivision (k), is necessary to correct an incorrect citation in the original regulation and prevent confusion.

The amendment to section 1300.75.4.8, subdivision (l) is necessary to clarify that the CAP Reporting requirements apply to sub-delegating organizations and that the timeline for organizations to the plan and the Department is five (5) calendar days.

AMENDMENTS TO TITLE 28, SECTION 1300.76.

The amendment to section 1300.76, subdivision (c)(1), is necessary to provide clarity to a definition of one of the components used to calculate the financial reserve amount required of organizations. Effective one year after the operative date of this rulemaking package, organizations shall demonstrate "positive" TNE¹¹ as defined by section 1300.76, proposed subdivision (c). The proposed requirements for TNE was reached by examining the requirements placed on a health plan and by examining how such a proposal would impact the healthcare market. The proposed level balances the need for organizations to have a level of financial reserves capable of demonstrating solvency while minimizing disparate impact on smaller organizations that may have more difficulty maintaining the required amount. This subdivision also clarifies that an organization's TNE shall be calculated without including the receivables of an affiliate with which an organization has a risk arrangement, except those arising in the normal course of business. The 60-day period is common business practice and is necessary to clarify the length of time a receivable may be applied as an asset for calculating TNE and to clarify and make specific what constitutes a "past due" obligation under the section.¹² Beyond this 60-day period the likelihood of such a receivable being paid diminishes. As previously stated, to assist a smooth transition to the revised TNE requirements, organizations are being given a year to become compliant with the new requirements. The Department has determined that the majority of organizations will not have significant difficulty meeting the more stringent reserve requirements.

SPECIFIC PURPOSE AND NECESSITY OF THE DEPARTMENT'S ANNUAL FINANCIAL SURVEY REPORT FORM

¹¹ Section 1375.4, subdivision (b)(1)(A)(iv).

¹² Generally Accepted Accounting Principles (GAAP) support that a dividing line should be specified at which accounts receivable become past due and uncollectible. (Financial Accounting Standards Board (FASB), Accounting Standards Codification, 310-10-35-7 through 35-11; Practitioner's Publishing Co.'s GAAP Guide 2013, chap. 40, paras. 40.204 and 40.205.) While GAAP does not specify a precise number of days for establishing uncollectible/past due receivables, the use of aging by days is a standard business practice that has been utilized in the field of accounting for a long period of time by accountants, and the use of 60 days is within the normal range of values. Going back several decades, the Department has consistently utilized a 60-day value in this context to be consistent with industry standards.

The *DMHC Annual Financial Survey Report Form* (annual financial survey report), dated May, 2018 is incorporated by reference into section 1300.75.4.2, subdivision (c), of the Regulations. The adoption of this form will result in the benefit of greater clarity regarding the Department's expectations of organizations for annual financial reporting. A version of this form was previously used by the impacted entities but was never incorporated by reference by the Department.

Each provision's purpose and necessity are set forth below.

RBO Details: is needed to identify the RBO that is providing the information and the contact information for the RBO if the Department has questions about the information provided. The following information is required:

- Page 1, Item 1, "RBO" – This addition is necessary identify the organization that is the subject of the annual financial survey report. This allows the Department to easily identify the filing and filer being reviewed.
- Page 1, Item 2, "Created By" – This addition is necessary to identify the person providing the annual financial survey report to the Department. This allows the Department to know who to contact if there are any problems with the filing of the annual financial survey report or additional information that may be needed.
- Page 1, Item 3, "Date Created" – This addition is necessary to indicate the date the annual financial survey report was started. This allows the Department to keep accurate records of compliance as required under the Knox-Keene Act and the Regulations.
- Page 1, Item 4, "Date Completed" – This addition is necessary to indicate the date the annual financial survey report was completed. This allows the Department to keep accurate records of compliance and for organizations to ensure that the annual financial survey report was submitted in a timely manner as required under the Knox-Keene Act and the Regulations.
- Page 1, Item 5, "Year" – This addition is necessary to indicate the reporting year the annual financial survey report relates to. This allows the Department and organization to keep accurate records and allows for efficient search and review functions.
- Page 1, Item 6, "Audit Opinion" – This information is necessary to indicate the type of opinion that was issued with the audited financial statements. The organization shall designate whether the type of audit opinion is an unqualified opinion, qualified opinion, disclaimer of opinion or adverse opinion for the Department to evaluate.
- Page 1, Item 7, "Combining Schedules" - This addition is necessary to indicate whether the annual financial survey report is on a combining basis with an affiliate. This requirement allows the organization to respond pursuant to proposed section 1300.75.4.2, subdivision (c)(1)(B) and gives the Department necessary information for evaluating the financial solvency of the organization and its contracts.
- Page 1, Item 8, "Report Status" – This addition is necessary to indicate whether the report has been completed or remains open. This allows the Department and organization to track the status of reports and ensure they are being issued in a timely manner.
- Page 1, Item 9, "Audit Firm" - This addition is necessary to disclose the audit firm that prepared the report. This allows the Department to know who to contact if there are any

problems or inconsistencies with the annual financial survey report. The audit firm shall provide the following information:

- “Firm Name” - This addition is necessary to identify the audited firm of the organization’s financial information. This allows the Department to easily identify the audit firm that performed the audit in case additional information is needed.
 - “Contact First Name” - This addition is necessary to disclose the contact person at the audit firm who prepared the report. This allows the Department to know who to contact if there are any problems or inconsistencies with the RBO’s audit report.
 - “Contact Last Name” - This addition is necessary to disclose the contact person at the audit firm who prepared the report. This allows the Department to know who to contact if there are any problems or inconsistencies with the RBO’s audit report.
 - “Phone” – This addition is necessary to provide the contact information for the contact person at the audit firm who prepared the report. This allows the Department to know who to contact if there are any problems or inconsistencies with the RBO’s audit report.
 - “Email” – This addition is necessary to provide the contact information for the contact person at the audit firm who prepared the report. This allows the Department to know who to contact if there are any problems or inconsistencies with the RBO’s audit report.
- Page 1, Item 10, “Reinsurance and Professional Stop-Loss” - This addition is necessary for the organization to disclose their management of risk arrangements. The options that an organization may select are:
- “Reinsurance” – This addition is necessary for an organization to indicate they use the insurance-based mechanism for the management of risk arrangements. Disclosure of this information allows the Department to fully assess the organizations risk arrangements and ensure financial viability.
 - “Professional Stop-Loss” – This addition is necessary for an organization to indicate that they use a contractual-based mechanism for the management of a risk-arrangement. Disclosure of this information allows the Department to fully assess the organizations risk arrangements and ensure financial viability.
 - “Self insure” – This addition is necessary for an organization to indicate that the organization itself has a reserve set-aside for the management of risk. Disclosure of this information allows the Department to fully assess the organizations risk arrangements and ensure financial viability.
- Page 1, Item 11, “Notes\Combining Schedules\Annual Audit Report Upload” – This addition is necessary for an organization to upload notes, combined schedules, or the annual audit report. A date will post showing the date the document was uploaded. This allows the Department and organization to track the status of reports and ensure they are

consistent with the information reported in the survey form and as required under the Knox-Keene Act and the Regulations.

Statement of Organization (description of structure): is necessary pursuant to section 1300.75.4.2, subdivision (d) of the Regulations, which requires submission of specific information relating to the structure of organization.

Statement of Organization – Detail: is necessary to understand the operational structure and ownership of the organization. The following information is required:

- Page 1, Item 12, “RBO Model” – This addition is necessary for the organization to disclose their provider organization model type and allow the Department to identify the type of financial arrangement more easily. The organization shall designate whether the type of “RBO Model” is an IPA, medical group, IPA/medical group combination, foundation, or other. This assists the Department in understanding the organization’s ability to assume risk and ensure viability.
- Page 1, Item 13, “Legal Ownership” - This addition is necessary for the organization to disclose its legal status. This assists the Department in understanding the organization’s ability to assume risk and ensure viability. The organization shall designate whether the type of “Legal Ownership” is a professional corporation, partnership, not-for-profit corporation/foundation, sole proprietorship, or other.
- Page 1, Item 14, “RBO Ownership” – This addition is necessary for the organization to declare whether they are partially or wholly owned by a hospital or healthcare system. If there is an affiliated relationship between the RBO and a hospital or healthcare system, additional detail (organization name/relationship) is required. This assists the Department in understanding the organization’s ability to assume risk and ensure viability.
- Page 1, Item 15, “**MSO Information**” - This addition is necessary for the organization to disclose if it is using a management services organization (MSO) that provides administrative services to the organization. This allows the Department to understand who may be responsible for processing provider claims. The requirement that the MSO contact information be disclosed allows the Department to know who to contact if there are any problems with the administrative services and the processing of claims. The following information shall be included:
 - “Name” - This addition is necessary identify the MSO that has contracted with the organization to provide administrative services. This allows the Department to easily identify the MSO and understand the type of contracting arrangement of the organization.
 - “Address” - This addition is necessary to provide the contact information for the contact person at the MSO. This allows the Department to know who to contact if there are problems with the administrative services and the processing of claims.
 - “City, State, Zip” - This addition is necessary to provide the contact information for the contact person at the MSO. This allows the Department to know who to contact if there are problems with the administrative services and the processing of claims.

- “Contact Title” - This addition is necessary to disclose the title of the contact person at the MSO. This allows the Department to know who to contact at the MSO if there are problems with the administrative services and the processing of claims.
 - “Contact First Name” - This addition is necessary to disclose the contact person at the MSO that prepared the report. This allows the Department to know who to contact if there are problems with the administrative services and the processing of claims.
 - “Contact Last Name” - This addition is necessary to disclose the contact person at the MSO that prepared the report. This allows the Department to know who to contact if there are problems with the administrative services and the processing of claims.
 - “Contact Phone” – This addition is necessary to provide the contact information for the contact person at the MSO. This allows the Department to know who to contact if there are problems with the administrative services and the processing of claims.
 - “Contact Email” – This addition is necessary to provide the contact information for the contact person at the MSO. This allows the Department to know who to contact if there are problems with the administrative services and the processing of claims.
 - “MSO related to the RBO?” – This addition is necessary for the organization to disclose whether the MSO is a related party to the RBO. The organization simply responds to this inquiry with either a “yes” or “no”. This allows the Department to recognize when there may be underlying issues with how this contract is arranged between the parties.
- Page 1, Item 16, **“Dispute Resolution Mechanism Contact”** - This addition is necessary for the organization to disclose where providers may access written information and instructions for filing provider disputes with the organization’s dispute resolution mechanism. This provides clarity and transparency to the contracted providers and ensures the organization is compliant with the Knox-Keene Act and the Regulations. The following information shall be included:
- “Address” - This addition is necessary to provide the contact information for the organization’s dispute resolution mechanism. This provides clarity and transparency to the contracted providers about how to use the dispute resolution process.
 - “City, State, Zip” - This addition is necessary to provide the contact information for the organization’s dispute resolution mechanism. This provides clarity and transparency to the contracted providers about how to use the dispute resolution process.
 - “Phone” – This addition is necessary to provide the contact information for the organization’s dispute resolution mechanism. This provides clarity and transparency to the contracted providers about how to use the dispute resolution process.

- “Website” – This addition is necessary to provide the contact information for the organization’s dispute resolution mechanism. This provides clarity and transparency to the contracted providers about how to use the dispute resolution process.

- Page 1, Item 17, “Counties Served by the RBO” - This addition is necessary for the organization to list the counties in which it provides health care services to enrollees. This allows the Department to review the size of the healthcare market the organization participates in and ensure that the financial viability of the organization to participate in those market areas is sufficient.

- Page 1, Item 18, **“RBO Lives Under Risk Arrangements”** - This addition is necessary for the organization to disclose the number of enrollees provided services and the type of risk arrangements for those services. This allows the Department to assess the risk associated with each organization and the potential risks to the healthcare market if the organization becomes insolvent. Additionally, this information allows the Department to ensure that a health plan’s enrollees have appropriate and timely access to providers, including specialists. The organization shall provide numerical data on each of the following:
 - “Commercial Percentage of RBO Lives Under Risk Arrangements” – This is necessary for the disclosure of number of enrollees the organization provides services to under this type of risk arrangement.
 - “Medicare Advantage Percentage of RBO Lives Under Risk Arrangements” – This is necessary for the disclosure of number of enrollees the organization provides services to under this type of risk arrangement.
 - “Medi-Cal Percentage of RBO Lives Under Risk Arrangements” - This is necessary for the disclosure of number of enrollees the organization provides services to under this type of risk arrangement.
 - “Total Percentage of All Capitated Lives (should = 100%)” - This is necessary for the disclosure of number of enrollees the organization provides services to under this type of risk arrangement.
 - “Total RBO Lives Under Risk Arrangements” – This is necessary for disclosure of the total lives under the risk arrangements.
 - “Total Primary Care Physicians in Employment or Under Contractual Arrangements” – This addition is necessary for the organization to disclose the number of primary care physicians that are employed or under contract with the RBO. This allows the Department to review the number of primary care physicians that are under contractual arrangements. Also, this information is required to be made available on the Department’s website for public inspection.
 - “Total Specialist Physicians in Employment or Under Contractual Arrangements” - This addition is necessary for the organization to disclose the number of specialist physicians that are employed or under contractual arrangements with the organization. This allows the Department to review the number of specialized physicians that are under contractual arrangements. Also,

this information is required to be made available on the Department's website for public inspection and easy public access.

- Page 2, Item 19, **“Affiliate Information”** - Affiliate Information is necessary for the organization to disclose any relationship it has with an affiliate to determine financial viability. This allows the Department to understand any third-party transactions between the organization and affiliate and evaluate the financial solvency of the transaction.
 - “Affiliate Business Name” - This addition is necessary to identify any affiliate that is associated with the organization. This allows the Department to easily identify the affiliate.
 - “Affiliate Address” - This addition is necessary to disclose the contact information at the affiliate that is associated with the organization. This allows the Department to keep accurate records.
 - “City, State, Zip” - This addition is necessary to disclose the contact information at the affiliate that is associated with the organization. This allows the Department to keep accurate records.
 - “Contact First Name” - This addition is necessary to disclose the contact information at the affiliate that is associated with the organization. This allows the Department to keep accurate records.
 - “Contact Last Name” - This addition is necessary to disclose the contact information at the affiliate that is associated with the organization. This allows the Department to keep accurate records.
 - “Contact Phone” - This addition is necessary to disclose the contact information at the affiliate that is associated with the organization. This allows the Department to keep accurate records.
 - “Contact Email” - This addition is necessary to disclose the contact information at the affiliate that is associated with the organization. This allows the Department to keep accurate records.
- Page 2, Item 20, **“Contracted Health Plans”** - This information is necessary for the Department to understand the organization contracts with health plans to provide health care services to the health plan's enrollees.
 - “Health Plan” - The organization shall note the health plan and whether the contract is for commercial products, Medicare Advantage, or Medi-Cal. This allows the Department to ensure the requirements under the Solvency Regulations are met and the appropriate health plans are notified of CAP proposals, so they may timely respond.
- Page 2, Item 21, **“Contracted Organizations”** - This addition is necessary for the organization to disclose the organizations with which the organization has contracted to delegate the responsibility of providing health care services to a health plan's enrollees.
 - “Organization” - The organization shall note the contracted organizations and whether the contract is for commercial products, Medicare Advantage, or Medi-

Cal. This allows the Department to ensure the requirements under the Solvency Regulations are met and that the appropriate organizations are notified of CAP proposals, so they may timely respond.

- Page 2, Item 22, **“Reimbursement for Specialists”** - This addition is necessary for the organization to disclose how the organization compensates each type of specialists.
 - “Specialists” - The specialists and type of product (commercial, Medicare Advantage, or Medi-Cal) must be noted. This compensation is represented in a percentage, rather than a dollar figure, based on whether the specialist is paid on a capitated, fee-for-service, or salary / retainer basis. This protects the contract negotiations of the organization and the provider by not disclosing the actual fee, just the type of fee paid. This allows the Department to understand the potential financial risk the organization is undertaking or passing on based on the type of payment.
- Page 2, Item 23, **“Foundation Information”** - This information is necessary to provide additional information about the organizational structure and whether it is a medical foundation exempt from licensure pursuant to subdivision (l) of Section 1206 of the Health and Safety Code.
 - “Name” - This addition is necessary identify the Foundation. This allows the Department to maintain accurate records.
 - “Address” - This addition is necessary to provide the contact information for the foundation. This allows the Department to keep accurate records.
 - “City, State, Zip” - This addition is necessary to provide the contact information for the foundation. This allows the Department to keep accurate records.

The organization shall provide a yes or no response on each of the following:

- “Does the medical group directly contract with a health plan?” – This information is necessary to determine if the medical group has a direct contract with one or more health plans, which is necessary to determine if the medical group qualifies as a risk-bearing organization.
- “Does the medical group arrange for health care services for enrollees?” – This information is necessary to determine if the medical group arranges for health care services for the health plan enrollees, which is necessary to determine whether the medical group qualifies as a risk-bearing organization.
- “Does the medical group receive compensation on a capitated or fixed periodic payment basis?” – If the medical group contracts with a health plan or arranges for services for the health plan enrollees, this information is necessary to determine how the medical group is compensated for providing the services to the health plan enrollees. Also, this information is necessary to determine whether the medical group qualifies as a risk-bearing organization.
- “Is the medical group directly responsible for the processing and payment of claims for services rendered under the capitated or fixed payment arrangement?” – If the

medical group processes and pays claims on behalf of the health plan that are covered under the capitated or fixed periodic payment, this information is necessary to determine whether the medical group qualifies as a risk-bearing organization.

The organization shall provide numerical data on each of the following:

- “Total HMO Revenue” – is revenue received from HMOs including withholds, refunds, insurance services, capitation, co-payments that are received on an ongoing basis.
- “Total Non-HMO Revenue” – is fee-for-service revenue including Preferred Provider Organization, Health Savings Account and cash payments, net of contractual and bad debt allowances.
- “Total Revenue” – is the sum of all revenues for the medical group.
- “Total Professional Fees” – is the sum of all healthcare costs incurred by the medical group.
- “All Other Expenses” – is the sum of all administrative and other expenses (administrative services, compensation and fringe benefits, interest expenses, occupancy, depreciation/amortization, management fees, marketing and income taxes).
- “Total Expenses” - is the sum of all expenses incurred by the medical group.

Balance Sheet: The balance sheet is necessary for the Department to evaluate the financial solvency of an organization. The following details the information required in the balance sheet:

Current Assets: is necessary to delineate that the following rows will list assets available to the organization during the current period. It is necessary this information be detailed to show the types of assets being used by the organization to calculate its solvency for review and evaluation by the Department.

- Row 1: “Cash and Cash Equivalents (Schedule A)” requires the organization to report cash or cash equivalents held in the bank or on hand, available for current use.
- Row 2: “Short-Term Investments” are 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.
- Row 3: “HMO Capitation Receivable – Net (collectible within 30 days) (Schedule B)” are gross amounts collectible from Health Maintenance Organizations (HMO) (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. The total balance for this item should be allocated across the aging schedule based upon the contract year, which generated the receivable.
- Row 4: “HMO Capitation Receivable-Net (collectible beyond 30 days) (Schedule B)” are 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.

- Row 5: “Non-HMO/Fee-for-Service Receivable – Net (Schedule B)” are 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.
- Row 6: “HMO Receivable-Net (Schedule B)” are gross amounts collectible from HMOs for receivables other than those through a capitated or fixed periodic payment, such as withholds and refunds.
- Row 7: “Risk Pool Receivable – Net (Schedule B)” are 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.
- Row 8: “Other Incentive Program Receivables – Net (Schedule B)” are 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.
- Row 9: “Secured Affiliate Receivable - Net (Schedule B)” are 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.
- Row 10: “Unsecured Affiliate Receivable – Net (Schedule B)” are 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.
- Row 11: “Other Receivable-Net (Schedule B)” are gross amounts expected to be collected from other sources not previously disclosed, less amounts accrued for receivables.
- Row 12: “Other Current Assets” are other current assets including prepayments, supply inventories and other items that are not included in the current asset categories. If the total of this row is more than 15% of all current assets reported on rows 1-12, the itemization for this line item must include the details (description and amount).
- Row 13: “**Total Current Assets**” is the total of the above listed categories in rows 1-12.

Other Assets: is necessary to delineate that the following rows will list other assets not listed in rows 1-12 for the current period. It is necessary that information be detailed to show the types of assets being used by the organization to calculate its solvency for review and evaluation by the Department.

- Row 14: “Long-term Investments” are investments intended to be held for a period longer than twelve months.

- Row 15: “Intangible Assets and Goodwill-Net” are assets of no physical substance; may include goodwill, software, covenants not to compete, patents, copyrights, licenses, franchises, etc., all net of accumulated amortization.
- Row 16: “Risk Pool Receivable (Non-Current) (Schedule B)” are amounts which 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.
- Row 17: “Other Incentive Program Receivables (Non-Current) (Schedule B)” are amounts collectible for the organization’s incentive receivables, net of bad debt allowances.
- Row 18: “Secured Affiliate Receivables - Long-Term (Schedule B)” are any secured non-current (over 365 days) accounts receivable from a parent, subsidiary and/or affiliates.
- Row 19: “Unsecured Affiliate Receivables – Long-Term (Schedule B)” are any unsecured non-current accounts receivable that is past due from parent, subsidiary and/or affiliate.
- Row 20: “Other Non-Current Assets” are other non-current assets that were not reported in previous categories. If the total of this row is more than 15% of all non-current assets reported on rows 14-20, the itemization for this line item must include the details (description and amount).
- Row 21: “Total Other Assets” total of the above listed categories in rows 14-20.
- Row 22: “Total Property and Equipment – Net” is all property, plant, and equipment, net of accumulated depreciation.
- Row 23: “**Total Assets**” is the total of rows 13, 21, and 22.

Current Liabilities: is necessary to delineate that the following rows will list the liabilities of the organization for the current period. It is necessary this information be detailed to show the types of liabilities incurred by the organization to calculate its solvency for review and evaluation by the Department to determine financial viability.

- Row 24: “Trade Accounts Payable” is 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” is amounts due to capitated providers (i.e. physicians, medical groups/IPAs, etc.) for medical services rendered to enrollees of the organization.
- Row 26: “Claims Payable (excluding Incurred But Not Reported Claims)” is claims received but not paid, but not including Incurred But Not Reported Claims, pursuant to section 1300.77.4 of the Regulations.
- Row 27: “Incurred But Not Reported Claims (Schedule C)” is 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” is 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 29: “Other Medical Liability” is all other medical liabilities due that are not reported in the above categories.
- Row 30: “Loans and Notes Payable (Current)” is the principal amount due on loans and notes payable within one year.

- Row 31: “Amounts Due to Affiliates (Current)” are liabilities owed to affiliates in the normal course of business.
- Row 32: “Other Current Liabilities” are all other current liabilities. Include all items that are not included in the current liability categories. If the total of this row is more than 15% of all current liabilities reported on rows 24-32, the itemization for this line item must include the details (description and amount).
- Row 33: “Total Current Liabilities” is the total of the liabilities listed in rows 24-32.

Other Liabilities: is necessary to delineate that the following rows will list other liabilities of the organization not previously listed for the current period. It is necessary this information be detailed to show the liabilities being incurred by the organization to calculate its solvency for review and evaluation by the Department to determine financial viability.

- Row 34: “Loans and Notes Payable (not subordinated) (Long-Term)” is 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)” is the principal amount due on loans and notes that are subordinated, including the current portion.
- Row 36: “Accrued Subordinated Interest Payable” is the accrued interest due on any subordinated loan and/or notes.
- Row 37 “Amounts Due to Affiliates (Long-Term)” are long term liabilities owed to affiliates in the normal course of business.
- Row 38: “Other Long-Term Liabilities” are all other long-term liabilities that are not included above. If the total of this row is more than 15% of all other liabilities reported on rows 34-38, the itemization for this line item must include the details (description and amount).
- Row 39: “Total Other Liabilities” is the total of the liabilities listed in rows 34 – 38.
- Row 40: “Total Liabilities” is the total of the liabilities in row 33 and 39.

Net Worth: is necessary to delineate that the following rows detail the calculations for net worth of an organization for the current period. It is necessary this information be detailed to show the types of assets being used by the organization to calculate its solvency for review and evaluation by the Department.

- Row 41: “Capital” is the cumulative amount of capital contributions including stock.
- Row 42: “Additional Paid-In Capital” is the excess amount of capital contributions for the period (including paid-in capital over stock par or stated value).
- Row 43: “Retained Earnings (deficit/fund balance)” is the cumulative earnings or deficit from operations, net of reserves and restricted funds.
- Row 44: “Other Net Worth Items” is all other net worth items that are not included above.
- Row 45: “Total Net Worth” is the total of Net Worth Categories in rows 41 – 44.
- Row 46: “Total Liabilities and Net Worth” is the total of Total Liabilities and Net Worth (row 40 and row 45).

Statement of Net Worth: is necessary to provide greater detail to the “net worth” rows in the Balance Sheet above (rows 41 – 45). This table provides a more detailed analysis on how the values in the Net Worth section are reached, providing the Department greater understanding of the solvency and financial viability of an organization.

- Row 1: “Net Worth Beginning of Period” is the starting value carried over from the previous fiscal year.
- Row 2: “Audit Adjustments” are any adjustments to the above reported net worth that occurred as a result of an audit.
- Row 3: “Increase (Decrease) in Stock” is any adjustment to the value of the organization’s stock, if any.
- Row 4: “Increase (Decrease) in Additional Paid-In Capital” is any additional capital paid-in to the organization, if any, or any loss of capital paid-in to the organization.
- Row 5: “Increase (Decrease) in Contributed Capital” is any capital contributed or lost to the organization during that period, if any.
- Row 6: “Increase (Decrease) in Retained Earnings” are any other earnings either gained or lost during the period.
- Row 7: “Net Income (Loss)” is the value reported in row 14 of the Income Statement listed below.
- Row 8: “Distributions to Shareholders” is the value of any distributions to shareholders that occurred during that period and, therefore, reduce the assets available to the organization.
- Row 9: “Changes in Other Net Worth Items” allows the organization to report any other changes to the net worth of an organization during the period.
- Row 10: “Net Worth End of Period” is the sum of the changes to net worth at the end of the period.

Income Statement: is necessary for the organization to demonstrate the financial performance over a specific accounting period, quarterly and annual. The income and expense information provide the Department clear information on the ability of an organization to maintain solvency and financial viability during the year to date.

Revenues: are necessary to delineate that the following rows detail the calculations for the revenue of an organization. It is necessary this information be detailed to show the types of revenues being used by the organization to calculate its solvency for review and evaluation by the Department.

- Row 1: “HMO Revenue” is 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” is 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 (Schedule D)” is 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 4: "Other Incentive Pool Revenue (Schedule D)" are revenues earned from any other incentive pools.
- Row 5: "Other Revenue" is any other source of revenues not listed above.
- Row 6: "Total Revenue" is the sum of all revenue categories in rows 1-5.

Expenses: are necessary to delineate that the following rows detail the calculations for expenses of an organization. It is necessary this information be detailed to show the types of expenses being incurred by the organization to calculate its solvency for review and evaluation by the Department.

- Row 7: "Physician and Physician Extender-Salary & Benefits" is 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" is 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 9: "Pharmacy Expense" refers to fees incurred by the organization for providing prescription drugs to enrollees.
- Row 10: "Other Medical Expenses (Capitated)" is all other capitated medical professional services that are not reported above.
- Row 11: "Other Medical Expenses (Non-Capitated)" is all other non-capitated medical professional services that are not reported above.
- Row 12: "Administration and Other Expenses (Schedule E)" 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" is the sum of the expenses listed in rows 7 – 12.
- Row 14: "Income (Loss) Before Provision for Income Taxes" is the earnings or loss before taxes, expressed as row 6 minus row 13.
- Row 15: "Income Taxes" is an estimate of taxes levied by the government on income for the organization.
- Row 16: "**Net Income (Loss)**" is the earnings after all expenses and taxes have been deducted.

Statement of Cash Flows: is necessary to demonstrate the changes in cash flows over the period as classified by operating, investing, and financing activities. It also provides reconciliation and adjustments to net cash provided by operating activities. This information provides the Department clear information on the cash inflows and outflows of the organization. An organization is required to give this information for the current reporting period.

“CASH FLOW PROVIDED (USED) BY OPERATING ACTIVITIES” is necessary to delineate that the following rows detail the calculation of operational cash flows of an organization. It is necessary this information be detailed to show the types of cash flow being used by the organization to operate its activities and demonstrate its solvency for review and evaluation by the Department.

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

“CASH FLOW PROVIDED (USED) BY INVESTING ACTIVITIES” is necessary to delineate that the following rows detail the calculation of investing cash flows of an organization. It is necessary that this information be detailed to show the cash flow used by the organization for investing to assist the Department in calculating the organization’s overall solvency for review and evaluation.

- Row 10: “Investments” is the amount of cash or cash equivalents an organization receives or uses from the purchase or sale of Investments (non-Trading).
- Row 11: “Property, Plant and Equipment” is the amount of cash or cash equivalents an organization receives or uses from the purchase or sale of Property, Plant, and Equipment.
- Row 12: “Other Long-Term Assets” is the amount of cash or cash equivalents an organization receives or uses from the purchase or sale of Other Long-Term Assets.
- Row 13: **“NET CASH PROVIDED (USED) BY INVESTING ACTIVITIES”** is the amount of cash or cash equivalents an organization receives or uses to pay ongoing investing activities.

“CASH FLOW PROVIDED (USED) BY FINANCING ACTIVITIES” is necessary to delineate that the following rows detail the calculation of financing cash flows of an organization. It is necessary that this information be detailed to show the used by the

organization for financing the organization's activities to assist the Department in calculating the organization's overall solvency for review and evaluation.

- Row 14: "Capital or Stock Issuance" is the amount of cash or cash equivalents an organization receives or uses from Capital or Stock Issuance.
- Row 15: "Loans (Affiliates)" is the amount of cash or cash equivalents an organization receives or uses from affiliated loans.
- Row 16: "Loans (Non-Affiliates)" is the amount of cash or cash equivalents an organization receives or uses from non-affiliated loans.
- Row 17: "Dividends Paid" is the amount of cash or cash equivalents an organization uses for dividend payments to shareholders.
- Row 18: "Other Financing Activities" is 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**" is 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**" is the sum of the change in cash or cash equivalents the organization experienced during the reporting period.
- Row 21: "**CASH AND CASH EQUIVALENTS AT BEGINNING OF THE YEAR**" is the amount of cash and cash equivalents an organization had at the beginning of the reporting period.
- Row 22: "**CASH AND CASH EQUIVALENTS AT END OF THE YEAR**" is the amount of cash and cash equivalents an organization had at the end of the reporting period. This figure allows the Department to evaluate the net change in an organization's reserves.

"RECONCILIATION OF NET INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES" is necessary to delineate that the following rows detailing the reconciliation of net income to net cash provided by operating activities for an organization. It is necessary that this information be detailed to show the types of net income to net cash provided by operating activities being used by the organization to calculate its solvency for review and evaluation by the Department.

- Row 23: "Net Income" is the excess or deficiency of total revenues over total expenses. This is used as the baseline for the reconciliation for net cash provided by operating activities.

"ADJUSTMENTS TO RECONCILE NET INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES" is necessary to detail adjustments to reconcile net income to net cash provided by operating activities for an organization to assist the Department in reviewing and evaluating the solvency and financial viability of the organization.

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

- from net income to determine net cash provided by operating activities.
- Row 26: “Decrease (Increase) In Prepaid Expenses” is used to adjust changes in prepaid expenses from net income to determine net cash provided by operating activities.
 - Row 27: “Decrease (Increase) In Affiliated Receivables” is used to adjust changes in affiliated receivables from net income to determine net cash provided by operating activities.
 - Row 28: “Decrease (Increase) In Accounts Payable” is used to 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” is used to 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” is used to 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” is used to determine any other adjustments to net income needed to reconcile to net cash provided by operating activities.
 - Row 32: “**TOTAL ADJUSTMENTS**” is the sum of all adjustments to Net Income listed in rows 24-31.
 - Row 33: “**NET CASH PROVIDED BY OPERATING ACTIVITIES**” is the amount of cash or cash equivalents an organization receives or uses to pay ongoing operating expenses.

Grading Criteria: is necessary for an organization to self-attest to the grading criteria pursuant to the Solvency Regulations to assist the Department in reviewing and evaluating the solvency and financial viability of the organization. This information must include the following:

- “**Tangible Net Equity**” is necessary for an organization to self-attest to whether they maintained positive TNE during the reporting period pursuant to section 1300.75.4.2, subdivision (c)(3).
 - Row 1: “Net Equity” is the financial information taken from row 45 of the Balance Sheet.
 - Row 2: “Add Subordinated Debt” is the information from row 35 of the Balance Sheet.
 - Row 3: “Less Receivables from officers, directors and affiliates” is the information from rows 10 and 19 of the Balance Sheet.
 - Row 4: “Less Intangibles” is the information from row 15 of the Balance Sheet.
 - Row 5: “Tangible Net Equity” is the amount calculated from rows 1-4.
 - Row 6: “Required Tangible Net Equity (Schedule I)” is where the organization provides its required TNE, by using Schedule I.
 - Row 7: “Maintained a positive TNE at all times, for the reporting period” is where the organization shall state “Yes” or “No” if they were compliant with the TNE requirement at all times during the reporting period.

- **“Working Capital”** is necessary for the organization to self-attest to whether they meet the working capital requirements pursuant to the Solvency Regulations section 1300.75.4.2, subdivision (c)(3). This information assists the Department in reviewing and evaluating the solvency and financial viability of the organization.
 - Row 8: “Maintained a positive working capital at all times, for the reporting period.” is where the organization shall state “Yes” or “No” if they were compliant with the working capital requirement at all times during the reporting period.
 - Row 9: “Working capital must be calculated based on financial information at the last day of the reporting period” is where the organization shall provide its working capital calculation.

- **“Cash-to-Claims Ratio”** is necessary for the organization to self-attest to whether they meet the cash-to-claims ratio requirement pursuant to the section 1300.75.4.2, subdivision (c)(4) of the Solvency Regulations. This information assists the Department in reviewing and evaluating the solvency and financial viability of the organization.
 - Row 10: “Maintained the required cash-to-claims ratio, at all times, for the reporting period (section 1300.75.4.2, subdivision (c)(4))” is where the organization shall state “Yes” or “No” if they were compliant with the cash-to-claims ratio at all times during the reporting period.
 - Row 11: “Ratio must be based on financial information at the last day of the reporting period” is where the organization must provide its cash-to-claim calculation.

- **“Claims and IBNR”** is necessary for the organization to self-attest to the timeframe in which the organization paid claims and the methodology for calculating IBNR pursuant to 1300.75.4.2, subdivision (c)(2). This information assists the Department in reviewing and evaluating the solvency and financial viability of the organization.
 - Row 12: “Did the RBO reimburse, contest or deny at least 95% of claims within 45 working days over the course of any three-month period?” is where the organization shall state “Yes” or “No” if they were compliant with the claims timeliness requirement.”
 - Row 13: “Enter percentage” is where the organization enters their compliance percentage for claims timeliness.
 - Row 14: “Methodology for Calculating IBNR” allows the organization to select the methodology used to calculate IBNR. The selections are lag study, actuarial, estimation or other.
 - Row 15: “If other, describe the methodology of calculating IBNR” allows the organization to provide a description of its methodology if “Other” was the response to row 14.
 - Row 16: “Has the RBO estimated and documented, on a monthly basis, its liability for IBNR claims?” is where the organization states if they estimated and documented its liability for IBNR claims pursuant to a method specified in section

1300.77.2.

- Row 17: “Are IBNR estimates the basis for the financial statement submission?” is where the organization states “Yes” or “No” if the IBNR estimates are the basis for the financial reports.

Schedule A - Cash & Cash Equivalents

Schedule A is necessary to provide detail to the “cash and cash equivalents” row in the Balance Sheet above (row 1). This table provides an understanding of the cash sources of an organization and assists the Department in reviewing and evaluating the solvency and financial viability of the organization.

This information includes:

- Account type (Indicate if the account is restricted);
- Type of account;
- Balance as of the last day of the reporting period;
- Asset type; and
- Total of all balances.

Schedule B – Receivables

Schedule B is necessary to provide the Department with an understanding of the receivables reported in the Balance Sheet. This table provides a more detailed analysis on how the values are reached, providing the Department greater understanding of the solvency of an organization. This table is limited to entities that owe balances greater than 10% of the organization’s gross receivables. The total of all other receivables is to be grouped and the total entered on the line titled, "Aggregate Accounts Not Individually Listed." This information assists the Department in reviewing and evaluating the solvency and financial viability of the organization.

This information includes:

- Name of entity that owes the receivable to the organization (“Debtor”);
- The aging of each balance reported (31-60 days, 61-90 days, over 90 days);
- Total of the balances owed by the debtors;
- Total – Individual Listed Receivables; and
- Aggregate Accounts Not Individually Listed.

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

Schedule C is necessary to provide detail to the IBNR reporting section, “Claims and IBNR,” in the “Grading Criteria” page detailed below. An organization shall provide an explanation of the methodology of calculating the IBNR. This section provides an explanation on how the values are reached, providing the Department understanding of the claims liability accrual.

Schedule D – Risk Pool and Other Incentive Revenues

Schedule D is necessary to provide details to the “Risk Pool Revenues” and “Other Incentive Pool Revenues that are reported in the Income Statement (rows 3 & 4). This table provides a detailed analysis on how the values are reached, providing the Department greater understanding

of the solvency of an organization. This information includes:

- “Name” - The name of the entity the revenue is due from;
- “Balance” - The amount recorded as revenue;
- “Quarter Reported” - The quarter that the revenue was reported;
- “Accrual (Y/N)” - state if an accrual was recorded;
- “Received Date” – the date the revenue was collected; and
- “Description” – Provide a description of the risk pool or incentive revenue.

Schedule E – Administration and Other Expenses

Schedule E is necessary to provide detail to the “Administrative and Other Expenses” row in the Income Statement above. This table is necessary to provide the Department details regarding the organizations administrative expenses and to assist in evaluating the organization’s financial solvency. The expenses, which shall be reported year to date and includes expenses relating to board fees, bonuses to physicians, depreciation/amortization, distributions to officers, income tax expense, interest expense, management fees owed to an MSO, marketing expense, occupancy/rent, salaries of officers, salaries of others, and any other expenses.

Schedule F – Details of Enrollment

Schedule F is necessary for the organization to provide detail on the enrollment for which the organization is responsible for the health care services. This table provides the Department greater understanding of the source of the enrollment (from the health plan or RBO) and the number of enrollment by product (Commercial, Medi-Cal, and Medi-Care Advantage) that is assigned to the organization.

Schedule G - Inventory of Claims to be Processed (Count)

Schedule G is necessary to provide the Department with the inflows and outflows of claims processed on a monthly basis. The report requires the following information to be provided:

- Beginning balance – the number of claims in inventory on the 1st of the month;
- Claims received – add the number claims received during the month;
- Claims process/adjudicated – deduct the number of claims processed/adjudicated during the month;
- Adjustments – add/deduct the number of adjusted claims; and
- Ending balance – the number of claims in inventory at the end of the month.

Schedule H – List any Mergers, Acquisitions or Discontinued Operations During the Period

Schedule H is necessary for the Department to evaluate the solvency of an organization. A merger or acquisition may result in additional assets or liabilities being incurred that may not be otherwise explained in the financial survey report. This information shall include:

- The name of the entity that merged, acquired, or discontinued operations during the period;
- Description of the transaction (merger, acquisition, or discontinuation); and
- Effective date of the transaction.

Schedule I – REQUIRED TANGIBLE NET EQUITY (TNE) CALCULATION

Schedule I is necessary for the organization to self-attest to whether they meet the TNE requirements pursuant to the Solvency Regulations. This information assists the Department in reviewing and evaluating the solvency and financial viability of the organization. The rows below are used to make this determination:

- **“Minimum TNE Requirement”** is the minimum RBO TNE requirement as indicated in Section 1300.75.4.2, subdivision (c)(3).
- **“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 (row 1), Risk Pool Revenues (row 3) and Other Incentive Pool Revenues (row 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.”
- **“HEALTHCARE EXPENDITURES”** is the calculation used to report the non-capitated medical expenses. Healthcare expenditures are the summation of Medical Claims Expense (row 8), Pharmacy Expense (row 9), and Other Medical Expenses (Non-Capitated) (row 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 – Notes to Financial Statements

Schedule J is necessary because not all relevant financial information can be communicated through the amounts shown (or not shown) on the financial statements (Balance Sheet, Income Statement, Statement of Net Worth and Statement of Cash Flows. The Notes to financial statements are prepared in accordance with GAAP.

SPECIFIC PURPOSE AND NECESSITY OF THE DEPARTMENT’S QUARTERLY FINANCIAL SURVEY REPORT FORM

The *DMHC Quarterly Financial Survey Report Form* (“quarterly financial survey report”), dated May, 2018 is incorporated by reference into section 1300.75.4.2, subdivision (b) of the Regulations. The adoption of this form will result in the benefit of greater clarity regarding the Department’s expectations of organizations for quarterly financial reporting. Each provision’s purpose and necessity are set forth below.

RBO Details: is needed to identify the RBO that is providing the information and the contact information for the RBO if the Department has questions about the information provided. The following information is required:

- Page 1, Item 1, “RBO” – This addition is necessary identify the organization that is the subject of the Financial Report. This allows the Department to easily identify the filing and filer being reviewed.
- Page 1, Item 2, “Created By” – This addition is necessary to identify the person providing the Financial Report to the Department. This allows the Department to know who to contact if there are any problems with the filing of the Financial Report or additional information that may be needed.
- Page 1, Item 3, “Date Created” – This addition is necessary to indicate the date the report was started. This allows the Department to keep accurate records of compliance as required under the Knox-Keene Act.
- Page 1, Item 4, “Date Completed” – This addition is necessary to indicate the date the report was completed. This allows the Department to keep accurate records of compliance and for organizations to ensure that the report was submitted in a timely manner as required under the Knox-Keene Act and corresponding regulations.
- Page 1, Item 5, “Combining Schedules” - This addition is necessary to indicate whether the financial report is on a combining basis with an affiliate. This requirement allows the organization to respond pursuant to proposed section 1300.75.4.2, subdivision (b)(1)(B).
- Page 1, Item 6, “Report Status” – This addition is necessary to indicate whether the report has been completed or remains open. This allows the Department and organization to track the status of reports and ensure they are being issued in a timely manner.
- Page 1, Item 7, “Notes\Combining Schedules\Annual Audit Report Upload” – This addition is necessary for an organization to upload notes, combined schedules, or the annual audit report. A date will post showing the date the document was uploaded. This allows the Department and organization to track the status of reports and ensure they are consistent with the information reported in the survey form.

Balance Sheet: The balance sheet is a statement of the financial position of the organization stating the assets, liabilities, and equity during the reporting period. The balance sheet is used to illustrate the financial health of a business and assists the Department to evaluate the financial solvency of an organization. The following details the information required in the balance sheet:

Current Assets: The current assets are necessary to assist the Department in evaluating the financial solvency of the organization during the reporting period. This information is delineated in the following rows to list assets available to the organization for the current period.

- Row 1: “Cash and Cash Equivalentents (Schedule A)” requires the organization to report cash or cash equivalentents held in the bank or on hand, available for current use.
- Row 2: “Short-Term Investments” are 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.
- Row 3: “HMO Capitation Receivable-Net (collectible within 30 days) (Schedule B)” are 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. This information shall be provided on a quarterly basis as well as a year to date schedule to allow the Department to analyze the change that occurred and potential solvency trends for that organization.

- Row 4: “HMO Capitation Receivable – Net (collectible beyond 30 days) (Schedule B)” are 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. The total balance for this item should be allocated across the aging schedule based upon the contract year, which generated the receivable. This information shall be provided on a quarterly basis as well as a year to date schedule to allow the Department to analyze the change that occurred and potential solvency trends for that organization.
- Row 5: “Non-HMO/Fee-for-Service Receivable – Net (Schedule B)” are 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.
- Row 6: “HMO Receivable-Net (Schedule B)” are gross amounts collectible from HMOs for receivables other than those through a capitated or fixed periodic payment, such as withholds and refunds. This information shall be provided on a quarterly basis as well as a year to date schedule to allow the Department to analyze the change that occurred and potential solvency trends for that organization.
- Row 7: “Risk Pool Receivable – Net (Schedule B)” are 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. This information shall be provided on a quarterly basis as well as a year to date schedule to allow the Department to analyze the change that occurred and potential solvency trends for that organization.
- Row 8: “Other Incentive Program Receivables – Net (Schedule B)” are 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. This information shall be provided on a quarterly basis as well as a year to date schedule to allow the Department to analyze the change that occurred and potential solvency trends for that organization.
- Row 9: “Secured Affiliate Receivable - Net (Schedule B)” are amounts of secured current accounts receivable from parent, subsidiary, and/or affiliates, less the amount accrued for receivables determined to be uncollectible during the period. 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. This information shall be provided on a quarterly basis as well as a year to date schedule to allow the Department to analyze the change that occurred and potential solvency trends for that organization.
- Row 10: “Unsecured Affiliate Receivable - Net (Schedule B)” is any unsecured affiliate accounts receivable from parent, subsidiary and/or affiliates. This information shall be provided on a quarterly basis as well as a year to date schedule to allow the Department to analyze the change that occurred and potential solvency trends for that organization.

- Row 11: “Other Receivable-Net (Schedule B)” are gross amounts from other sources not previously disclosed, less amounts accrued for receivables determined to be uncollectible for the period.
- Row 12: “Other Current Assets” are other current assets including prepayments, supply inventories and other items that are not included in the other current asset categories.
- Row 13: “Total Current Assets” is the total of the above listed categories in rows 1-12.

Other Assets: This information is necessary to assist the Department in evaluating the financial solvency of the organization during the reporting period. This information is delineated in the following rows to list other assets not already listed in rows 1-12 for the current period.

- Row 14: “Long-term Investments” are investments intended to be held for a period longer than twelve months.
- Row 15: “Intangible Assets and Goodwill - Net” are assets of no physical substance; may include goodwill, software, covenants not to compete, patents, copyrights, licenses, franchises, etc., all net of accumulated amortization.
- Row 16: “Risk Pool Receivable (Non-Current) (Schedule B)” are amounts which 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. For the quarterly reports, this information shall be provided on a quarterly basis as well as a year to date schedule to allow the Department to analyze the change that occurred and potential solvency trends for that organization.
- Row 17: “Other Incentive Program Receivables (Non-Current) (Schedule B)” are amounts collectible for the organization’s incentive receivables, net of bad debt allowances. For the quarterly reports, this information shall be provided on a quarterly basis as well as a year to date schedule to allow the Department to analyze the change that occurred and potential solvency trends for that organization.
- Row 18: “Secured Affiliate Receivables - Long-Term (Schedule B)” are any secured non-current (over 365 days) accounts receivable from a parent, subsidiary and/or affiliates. For the quarterly reports, this information shall be provided on a quarterly basis as well as a year to date schedule to allow the Department to analyze the change that occurred and potential solvency trends for that organization.
- Row 19: “Unsecured Affiliate Receivables – Long-Term (Schedule B)” are any unsecured non-current accounts receivable that is past due from parent, subsidiary and/or affiliate. For the quarterly reports, this information shall be provided on a quarterly basis as well as a year to date schedule to allow the Department to analyze the change that occurred and potential solvency trends for that organization.
- Row 20: “Other Non-Current Assets” are other non-current assets that were not reported in previous categories. If the total of this line is more than 15% of all other assets reported on lines 14-20, the itemization for this line item must include the details (description and amount).
- Row 21: “Total Other Assets” total of the above listed categories in rows 14-20.
- Row 22: “Total Property and Equipment – Net” is all property, plant, and equipment, net of accumulated depreciation.
- Row 23: “Total Assets” is the total of rows 13, 21, and 22.

Current Liabilities: This information is necessary to assist the Department in evaluating the financial solvency of the organization. This information is delineated in the following rows to list the liabilities of the organization for the current reporting period.

- Row 24: “Trade Accounts Payable” are 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” are amounts due to capitated providers (i.e. physicians, medical groups/IPAs, etc.) for medical services rendered to enrollees of the organization.
- Row 26: “Claims Payable (excluding Incurred But Not Reported Claims)” are claims received but not paid, but not including Incurred But Not Reported Claims, pursuant to section 1300.77.4 of the Regulations. For the quarterly reports, this information shall be provided on a quarterly basis as well as a year to date schedule to allow the Department to analyze the change that occurred and potential solvency trends for that organization.
- Row 27: “Incurred But Not Reported Claims (Schedule C)” is 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” are 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 29: “Other Medical Liability” are all other medical liabilities due that are not reported in the above categories.
- Row 30: “Loans and Notes Payable (Current)” is the principal amount due on loans and notes payable within one year.
- Row 31: “Amounts Due to Affiliates (Current)” are liabilities owed to affiliates in the normal course of business.
- Row 32: “Other Current Liabilities” are all other current liabilities. Include all items that are not included in the current liability categories. If the total of this row 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).
- Row 33: “Total Current Liabilities” is the total of the liabilities listed in rows 24-32.

Other Liabilities: This information is necessary to assist the Department in evaluating the organization’s financial solvency. The information is delineated in the following rows to list other liabilities of the organization not previously listed for the current reporting period.

- Row 34: “Loans and Notes Payable (not subordinated) (Long-Term)” is 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)” is the principal amount due on loans and notes that are subordinated, including the current portion.
- Row 36: “Accrued Subordinated Interest Payable” is the accrued interest due on any subordinated loan and/or notes.
- Row 37: “Amounts Due to Affiliates (Long-Term)” are long term liabilities owed to affiliates in the normal course of business.

- Row 38: “Other Long-Term Liabilities” are 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 rows 34-37, the itemization for this line item must include the details (description and amount).
- Row 39: “Total Other Liabilities” is the total of the liabilities listed in rows 34 – 38.
- Row 40: “Total Liabilities” is the total of the liabilities in row 33 and 39.

Net Worth: This information is necessary to assist the Department in assessing the organization’s financial solvency. The information is delineated in the following rows to detail the calculations for net worth of an organization for the current reporting period.

- Row 41: “Capital” is the cumulative amount of capital contributions including stock.
- Row 42: “Additional Paid-In Capital” is the excess amount of capital contributions for the period (including paid-in capital over stock par or stated value).
- Row 43: “Retained Earnings (deficit/fund balance)” is the cumulative earnings or deficit from operations, net of reserves and restricted funds.
- Row 44: “Other Net Worth Items” is all other net worth items that are not included above.
- Row 45: “Total Net Worth” is the total of Net Worth Categories in rows 41– 44.
- Row 46: “Total Liabilities and Net Worth” is the total of Total Liabilities (row 40) and Total Net Worth (row 45).

Statement of Net Worth: This information is necessary to provide the Department detail to the “net worth” section in the Balance Sheet of the organization, as described above. This table provides a detailed analysis on how the values in the Net Worth section are reached, providing the Department understanding of the financial solvency of an organization for the current reporting period.

- Row 1: “Net Worth Beginning of Period” is the starting value carried over from the previous quarter.
- Row 2: “Audit Adjustments” are any adjustments to the above reported net worth that occurred as a result of an audit.
- Row 3: “Increase (Decrease) in Stock” is any adjustment to the value of the organization’s stock, if any.
- Row 4: “Increase (Decrease) in Additional Paid-In Capital” is any additional capital paid-in to the organization, if any, or any loss of capital paid-in to the organization.
- Row 5: “Increase (Decrease) in Contributed Capital” is any capital contributed or lost to the organization during that period, if any.
- Row 6: “Increase (Decrease) in Retained Earnings” are any other earnings either gained or lost during the period.
- Row 7: “Net Income (Loss)” is the value reported in the Income Statement listed above.
- Row 8: “Distributions to Shareholders” is the value of any distributions to shareholders that occurred during that period and, therefore, reduce the assets available to the organization.

- Row 9: “Changes in Other Net Worth Items” allows the organization to report any other changes to the net worth of an organization during the period.
- Row 10: “Net Worth End of Period” is the sum of the changes to net worth at the end of the period.

Income Statement: This information is necessary for the organization to demonstrate the financial performance over a specific accounting period, both quarterly and annual. The income and expense information provide the Department clear data on the ability of an organization to maintain financial solvency. This information is needed for the current reporting period and year-to-date.

Revenues: This information is necessary to provide the Department with a clear understanding of the financial solvency of the organization. The information is delineated in the rows detailing the calculations for the revenue of an organization. All revenues are reported for the current period (the reporting period) and the year-to-date (summation of all revenues from the first day of the fiscal year to the end of the reporting period):

- Row 1: “HMO Revenue” is 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” is 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 (Schedule D)” is 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 4: “Other Incentive Pool Revenue (Schedule D)” are revenues earned from any other incentive pools.
- Row 5: “Other Revenue” is any other source of revenues not listed above.
- Row 6: “Total Revenue” is the sum of all revenue categories in rows 1-5.

Expenses: This information is necessary to provide the Department with a clear understanding of the financial viability of the organization. The information is delineated in the rows detailing the calculations for the expenses of an organization. All expenses are reported for the current period (the reporting period) and the year-to-date (summation of all revenues from the first day of the fiscal year to the end of the reporting period):

- Row 7: “Physician and Physician Extender - Salary & Benefits” is 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” is 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 9: “Pharmacy Expense” refers to fees incurred by the organization for providing prescription drugs to enrollees.
- Row 10: “Other Medical Expenses (Capitated)” is all other capitated medical professional services that are not reported above.
- Row 11: “Other Medical Expenses (Non-Capitated)” is all other non-capitated medical professional services that are not reported above.
- Row 12: “Administration and Other Expenses (Schedule E)” 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” is the sum of the expenses listed in rows 7 – 12.
- Row 14: “Income (Loss) Before Provision for Income Taxes” is the earnings or loss before taxes, expressed as row 6 minus row 13.
- Row 15: “Income Taxes” is an estimate of taxes levied by the government on income for the organization.
- Row 16: “**Net Income (Loss)**” is the earnings after all expenses and taxes have been deducted.

Statement of Cash Flows: This information is necessary to demonstrate the changes in cash flows over the period as classified by operating, investing, and financing activities. It also provides reconciliation and adjustments to net cash provided by operating activities. This information provides the Department clear information on the cash inflows and outflows of the organization and is used by the Department to help assess the financial solvency of the organization. The information provide under this section is for the current reporting period.

“CASH FLOW PROVIDED (USED) BY OPERATING ACTIVITIES”: This information is necessary to provide the Department with information to assist in assessing the organization’s viability by demonstrating the way in which the organization’s cash flow is being used. The information is delineated in the following rows to detail the calculation of operational cash flows of the organization:

- Row 1: “Capitation Revenues” is the amount of cash or cash equivalents an organization receives from HMOs.
- Row 2: “Fee-for-Service Revenues” is the amount of cash or cash equivalents an organization receives on a Fee-for Service basis.
- Row 3: “Risk and Incentive Revenues” is the amount of cash or cash equivalents an organization receives from risk-sharing and incentive contracts.
- Row 4: “Other Revenues” is the amount of cash or cash equivalents an organization receives from other revenue sources.
- Row 5: “Medical Expenses” is the amount of cash or cash equivalents an organization uses to pay medical expenses.
- Row 6: “Administrative Expenses and Other Expenses” is the amount of cash or cash equivalents an organization uses to pay administrative expenses.
- Row 7: “Income Taxes” is the amount of cash or cash equivalents an organization receives or uses from federal income taxes.

- Row 8: “Interest” is the amount of cash or cash equivalents an organization receives or uses from investment and loans.
- Row 9: “**NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES**” is the amount of cash or cash equivalents an organization receives or uses to pay ongoing operating expenses.

“**CASH FLOW PROVIDED (USED) BY INVESTING ACTIVITIES**”: This information is necessary to assist the Department in assessing the organization’s financial viability by demonstrating the way in which the organization’s cash flow is being used. The information is delineated in the following rows detailing the calculation of investing cash flows of the organization:

- Row 10: “Investments” is the amount of cash or cash equivalents an organization receives or uses from the purchase or sale of Investments (non-Trading).
- Row 11: “Property, Plant and Equipment” is the amount of cash or cash equivalents an organization receives or uses from the purchase or sale of Property, Plant, and Equipment.
- Row 12: “Other Long-Term Assets” is the amount of cash or cash equivalents an organization receives or uses from the purchase or sale of Other Long-Term Assets.
- Row 13: “**NET CASH PROVIDED (USED) BY INVESTING ACTIVITIES**” is the amount of cash or cash equivalents an organization receives or uses to pay ongoing investing activities.

“**CASH FLOW PROVIDED (USED) BY FINANCING ACTIVITIES**”: This information is necessary to assist the Department in assessing the organization’s financial viability by demonstrating the way in which the organization’s financing is being done. The information is delineated in the following rows detailing the calculation of financing cash flows of the organization:

- Row 14: “Capital or Stock Issuance” is the amount of cash or cash equivalents an organization receives or uses from Capital or Stock Issuance.
- Row 15: “Loans (Affiliates)” is the amount of cash or cash equivalents an organization receives or uses from affiliated loans.
- Row 16: “Loans (Non-Affiliates)” is the amount of cash or cash equivalents an organization receives or uses from non-affiliated loans.
- Row 17: “Dividends Paid” is the amount of cash or cash equivalents an organization uses for dividend payments to shareholders.
- Row 18: “Other Financing Activities” is 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**” is 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**” is the sum of the change in cash or cash equivalents the organization experienced during the reporting period.
- Row 21: “**CASH AND CASH EQUIVALENTS AT BEGINNING OF THE**

QUARTER” is the amount of cash and cash equivalents an organization had at the beginning of the reporting period.

- Row 22: **“CASH AND CASH EQUIVALENTS AT END OF THE QUARTER”** is the amount of cash and cash equivalents an organization had at the end of the reporting period. This figure allows the Department to evaluate the net change in an organization’s reserves.

“RECONCILIATION OF NET INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES”: This information is necessary to assist the Department in assessing the financial viability of the organization by demonstrating how the organization is reconciling its net income to net cash provided by its operating activities. This information is delineated in the following rows detailing the reconciliation of net income to net cash provided by operating activities for the organization:

- Row 23: **“Net Income”** is the excess or deficiency of total revenues over total expenses. This is used as the baseline for the reconciliation for net cash provided by operating activities.

“ADJUSTMENTS TO RECONCILE NET INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES”: This information is necessary to assist the Department in assessing the financial viability of the organization by demonstrating how the organization is reconciling its net income to net cash provided by operating activities through adjustment. This information is delineated in the following rows detailing the adjustment to reconcile net income to net cash provided by operating activities of the organization for the reporting period:

- Row 24: **“Depreciation and Amortization”** is used to adjust depreciation and amortization (non-cash expenses) from net income to determine net cash provided by operating activities.
- Row 25: **“Decrease (Increase) In Receivables”** is used to adjust changes in receivables from net income to determine net cash provided by operating activities.
- Row 26: **“Decrease (Increase) In Prepaid Expenses”** is used to adjust changes in prepaid expenses from net income to determine net cash provided by operating activities.
- Row 27: **“Decrease (Increase) In Affiliated Receivables”** is used to adjust changes in affiliated receivables from net income to determine net cash provided by operating activities.
- Row 28: **“Decrease (Increase) In Accounts Payable”** is used to 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”** is used to 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”** is used to 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”** is used to determine any other adjustments to net income needed to reconcile to net cash provided

by operating activities.

- Row 32: **“TOTAL ADJUSTMENTS”** is the sum of all adjustments to Net Income listed in rows 24-31.
- Row 33: **“NET CASH PROVIDED BY OPERATING ACTIVITIES”** is the amount of cash or cash equivalents an organization receives or uses to pay ongoing operating expenses.

Grading Criteria: This attestation is necessary for an organization to self-attest to in order to meet the grading criteria pursuant to the requirements of the Solvency Regulations. The information includes the following:

- **“Tangible Net Equity”** is necessary for an organization to attest to whether they maintained positive TNE during the reporting period pursuant to section 1300.76 of the Regulations.
 - Row 1: “Net Equity” is the financial information taken from row 45 of the Balance Sheet.
 - Row 2: “Add Subordinated Debt” is the information from row 35 of the Balance Sheet).
 - Row 3: “Less Receivables from officers, directors and affiliates” is the information from rows 10 and 19 of the Balance Sheet.
 - Row 4: “Less Intangibles” is the information from row 15 on the Balance Sheet.
 - Row 5: “Tangible Net Equity” is the amount calculated from rows 1-4.
 - Row 6: “Required Tangible Net Equity (Schedule I)” is the TNE the organization provides using Schedule I.
 - Row 7: “Maintained a positive TNE at all times, for the reporting period” is where the organization shall state “Yes” or “No” if they were compliant with the TNE requirement at all times during the reporting period.
- **“Working Capital”** is necessary for the organization to self-attest to whether they meet the working capital requirements pursuant to section 1300.75.4.2, subdivision (b)(4), of the Regulations.
 - Row 8: “Maintained a positive working capital at all times, for the reporting period” is where the organization shall state “Yes” or “No” if they were compliant with the working capital requirement at all times during the reporting period.
 - Row 9: “Working capital must be calculated based on financial information at the last day of the reporting period” is where the organization shall provide its working capital calculation.
- **“Cash-to-Claims Ratio”** is necessary for the organization to self-attest to whether they meet the cash-to-claims ratio requirement pursuant to section 1300.75.4.2, subdivision (b)(5), of the Solvency Regulations.
 - Row 10: “Maintained the required cash-to-claims ratio, at all times, for the reporting period (section 1300.75.4.2, subdivision (b)(5))” is where the

- organization shall state “Yes” or “No” if they were compliant with the cash-to-claims ratio at all times during the reporting period.
- Row 11: “Ratio must be based on financial information at the last day of the reporting period” is where the organization must provide its cash-to-claim calculation.
 - **“Claims and IBNR”** is necessary for the organization to self-attest to the timeframe in which the organization paid claims and the methodology for calculating IBNR pursuant to 1300.75.4.2, subdivision (b)(3), of the Regulations.
 - Row 12: “Did the RBO reimburse, contest or deny at least 95% of claims within 45 working days over the course of any three-month period?” is where the organization shall state “Yes” or “No” if they were compliant with the claims timeliness requirement.
 - Row 13: “Enter percentage” is where the organization enters their compliance percentage for claims timeliness.
 - Row 14: “Methodology for Calculating IBNR” allows the organization to select the methodology used to calculate IBNR. The selections are lag study, actuarial, estimation or other.
 - Row 15: “If other, describe the methodology of calculating IBNR” allows the organization to provide a description of its methodology if “Other” was the response to row 14.
 - Row 16: “Has the RBO estimated and documented, on a monthly basis, its liability for IBNR claims?” is where the organizations state if they estimated and documented its liability for IBNR claims pursuant to a method specified in section 1300.77.2.
 - Row 17: “Are IBNR estimates the basis for the financial statement submission?” is where the organization states “Yes” or “No” if the IBNR estimates are the basis for the financial reports.

Schedule A - Cash and Cash Equivalents

Schedule A is necessary to provide greater detail to the Department’s understanding of the organization’s “cash and cash equivalents” row in the Balance Sheet, as described above. This table provides the Department with an understanding of the cash sources of the organization.

This information includes:

- Account type (Note whether the account is restricted);
- Type of account;
- Balance as of the last day of the reporting period;
- Asset type; and
- Total of all balances.

Schedule B - Receivables

Schedule B is necessary to provide the Department with an understanding of the receivables reported in the Balance Sheet as described above. This table provides a more detailed analysis on how the values are reached, providing the Department greater understanding of the solvency of the organization. This table is limited to entities that owe balances greater than 10% of the

organization's gross receivables. The total of all other receivables is to be grouped and the total enter on the line titled, "Aggregate Accounts Not Individually Listed." This information includes:

- Name of entity that owes the receivable to the organization ("Debtor");
- The aging of each balance reported (31-60 days, 61-90 days, over 90 days);
- Total of the balances owed by the debtors;
- Total – Individual Listed Receivables; and
- Aggregate Accounts Not Individually Listed.

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

Schedule C is necessary to provide detail to the IBNR reporting section, "Claims and IBNR," in the "Grading Criteria" page detailed below. An organization shall provide an explanation of the methodology of calculating the IBNR. This section provides an explanation on how the values are reached, providing the Department understanding of the claims liability accrual of the organization. This information is used by the Department in analyzing the financial viability of the organization.

Schedule D - Risk Pool and Other Incentive Revenues

Schedule D is necessary to provide details to the "Risk Pool Revenues" and "Other Incentive Pool Revenues" that are reported in the Income Statement. This table provides a detailed analysis on how the values are reached, providing the Department greater understanding of the solvency of an organization. This information includes:

- "Name" - the name of the entity the revenue is due from;
- "Balance" - the amount recorded as revenue;
- "Quarter Reported" - the quarter that the revenue was reported;
- "Accrual (Y/N)" - state if an accrual was recorded;
- "Received Date" – the date the revenue was collected; and
- "Description" – provide a description of the risk pool or incentive revenue.

Schedule E - Administration and Other Expenses

Schedule E is necessary to provide detail to the "Administrative and Other Expenses" row in the Income Statement above. This table is necessary to provide details regarding the organizations administrative expenses. The expenses shall be reported for both the current period and year-to-date. The information reported on includes board fees, bonuses to physicians, depreciation/amortization, distributions to officers, income tax expenses, interest expenses, management fees owed to an MSO, marketing, occupancy/rent, salaries of officers, salaries of others, and any other expenses. This information assists the Department in understanding how the expenses of the organization are leading to its overall financial viability.

Schedule F – Details of Enrollment

Schedule F is necessary for the organization to provide detail on the health plan enrollment for which the organization is responsible for the health care services. This table provides the Department greater understanding of the source of the enrollment (from the health plan or RBO) and the number of enrollment by product (Commercial, Medi-Cal, Medicare Advantage) that is

assigned to the organization.

Schedule G - Inventory of Claims to be Processed (Count)

Schedule G is necessary to provide the Department with the inflows and outflows of claims processed on a monthly basis to help the Department determine whether the organization is meeting its required functions. The report requires the following information be provided:

- Beginning balance – the number of claims in inventory on the 1st of the month;
- Claims received – add the number claims received during the month;
- Claims process/adjudicated – deduct the number of claims processed/adjudicated during the month;
- Adjustments – add/deduct the number of adjusted claims; and
- Ending balance – the number of claims in inventory at the end of the month.

Schedule H – List any mergers, acquisitions or discontinued operations during the period

Schedule H is necessary for the Department to evaluate the solvency of an organization and how it is structured during the reporting period. A merger or acquisition may result in additional assets or liabilities being incurred that may not be otherwise explained in the financial survey report. This information shall include:

- The name of the entity that merged, acquired, or discontinued operations during the period;
- Description of the transaction (merger, acquisition, or discontinuation); and
- Effective date of the transaction.

Schedule I – REQUIRED TANGIBLE NET EQUITY (TNE) CALCULATION

Schedule I is the Required Tangible Net Equity (TNE) Calculation. This information is necessary for the organization to self-attest to whether they meet the TNE requirements under the Solvency Regulations. This attestation assists the Department in assessing the financial viability of the organization. The rows below are used to make this determination:

- **“Minimum TNE Requirement”** is the minimum RBO TNE requirement as indicated in Section 1300.75.4.2, subdivision (b)(4).
- **“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 (row 1), Risk Pool Revenues (row 3) and Other Incentive Pool Revenues (row 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.”
- **“HEALTHCARE EXPENDITURES”** is the calculation used to report the non-capitated medical expenses. Healthcare expenditures are the summation of Medical Claims Expense (row 8), Pharmacy Expense (row 9), and Other Medical Expenses (Non-Capitated) (row 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 expenses, 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 – Notes to Financial Statements

Schedule J is necessary because not all relevant financial information can be communicated through the amounts shown (or not shown) on the financial statements (Balance Sheet, Income Statement, Statement of Net Worth, and Statement of Cash Flows). The Notes to financial statements are prepared in accordance with GAAP. This information will be used by the Department in connection with its review of the rest of the information in the form submitted by the organization to demonstrate its financial viability.

SPECIFIC PURPOSE AND NECESSITY OF THE *DEPARTMENT CORRECTIVE ACTION PLAN (CAP) FORM*

The *DMHC Corrective Action Plan (CAP) Form*, dated May, 2018, is incorporated by reference into section 1300.75.4.8, subdivision (a), of the Regulations. The adoption of this form will provide clarity to the Department’s expectations of organizations filing a self-initiated CAP proposal when financial viability issues are detected and will provide health plans and sub-delegating organizations an efficient and standardized form in which to review the CAP proposals. When an organization completes the above described *DMHC Quarterly Financial Survey Report Form* and indicates that the organization does not meet any of the grading criteria, the organization is then required to submit a CAP proposal on the *Department’s Corrective Action Plan (CAP) Form*. The information provided in the *Department Corrective Action Plan (CAP) Form* is distinct from the information provided in the *DMHC Quarterly Financial Survey Report Form* because it requires the organization to provide the current, “actual” financial information for the deficient quarter and then provide projections on how the organization will obtain compliance with the grading criteria. The Regulations allow up to 12 months to correct the TNE, working capital, and cash-to-claims deficiencies; up to six (6) months to correct claims timeliness deficiency; and up to three (3) months to correct IBNR deficiency. The Department may extend the period of time to correct the deficiency. The CAP Form uses “RBO” (risk-bearing organization) to refer to an organization. Each provision’s purpose and necessity are set forth below.

General Information: This addition is necessary for the organization to disclose its contact information to provide the Department an efficient way to contact the organization. The following information shall be included:

- “Date of CAP Report” is necessary to identify the date the organization submitted the CAP report.
- “RBO Number” is necessary to identify the organization that is the subject of the CAP. This allows the Department, health plans, and sub-delegating organizations to easily identify the RBO.
- “RBO Name” is necessary to identify the organization that is the subject of the CAP. This allows the Department, health plans, and sub-delegating organizations easily identify the RBO.

- “RBO Contact Name and Title” is necessary to disclose the title of the contact person at the organization. This allows the Department, health plans, and sub-delegating organizations know who to contact if there are questions regarding the CAP.
- “RBO Contact Telephone” is necessary to provide the contact information for the contact person at the organization. This allows the Department, health plans, and sub-delegating organizations to know the telephone number for the contact person if there are questions regarding the CAP.
- “RBO Contact E-mail Address” is necessary to provide the contact information for the contact person at the organization. This allows the Department, health plans, and sub-delegating organizations know the email information on who to contact for questions regarding the CAP.

Grading Criteria: This information is necessary for the Department to evaluate the financial solvency of the organization and assess the area of deficiency. The organization must include the solvency information based on the initial deficient quarter, the end of the current quarter, and whether the organization is in compliance with their final/approved CAP. If the organization is not meeting its final/approved CAP, the organization must provide a reason why they are not meeting their final/approved CAP. The grading criteria, the necessity for which is discussed above, include TNE, required TNE, working capital, cash-to claims ratio, claims timeliness, and estimated and documented IBNR pursuant to section 1300.77.2 of the Regulations.

Attestation: This attestation is required to ensure the information is true and accurate, as submitted by the principal officer of the organization.

Financial Assumptions: The financial assumptions are necessary for the organization to outline the specific actions being taken or implemented to resolve the organization’s financial solvency. This allows the Department, health plans, and sub-delegating organizations to review the actions and, when necessary, object to the assumptions. The following information will be provided as part of the financial assumptions:

- **“Specific Actions Being Taken/Implemented”** is necessary for the organization to detail the specific steps that will be taken to resolve the deficiency.
- **“Assistance From Contracting Health Plans or Sub-Delegating Organizations”** is necessary for the organization to detail any written representations communicated to the organization by a health plan or sub-delegating organization to assist in the implementation of the CAP.
- **“Expected Results & Milestones”** is necessary for the organization to detail expected milestones on a monthly or quarterly basis.
- **“Estimated Date of Completion for Each Specific Action”** is necessary for the organization to provide a date the organization expects to become compliant with the specific action.
- **“Deficiencies Addressed”** is necessary for the organization to list the financial solvency deficiencies that the CAP intends to address.
- **“Progress Achieved To Date”** is necessary for the organization to detail any progress towards compliance that has occurred as of the date of the report.

- **“DESCRIPTION OF ASSUMPTIONS USED IN DEVELOPMENT OF PROJECTIONS (INCLUDE ALL SUPPORTING SCHEDULES AND DOCUMENTS AS ATTACHMENTS TO CAP)”** is necessary for the organization to explain how the financial assumption projections were developed. This information is important for the Department, health plans, and sub-delegating organizations to understand how an organization will reach compliance with the grading criteria.
- **“List of all plans and sub-delegating organizations with which the Organization has contracts involving a risk arrangement”** is necessary for an organization to detail its contracts involving a risk arrangement. This allows the Department to ensure that all required parties have an opportunity to review and object to the proposed CAP. The organization must provide the name of the health plan or sub-delegating organization; title and name of the person responsible for monitoring CAP compliance; the telephone number of that contact person; postal address; and email address.

CAP Financial Projections and Assumptions: This is where the organization demonstrates how they will achieve compliance with the grading criteria. The Department needs this information to assess whether the financial projections and assumptions are valid and will achieve financial solvency for the organization.

Balance Sheet: The balance sheet is necessary for the Department to evaluate the financial solvency of an organization by evaluating its overall financial viability. The following information is required in the balance sheet:

Current Assets: This information is necessary for the Department’s review of the organization’s finances. The information is delineated in the following rows to list the assets available to the organization:

- Row 1: “Cash and Cash Equivalents” requires the organization to report cash or cash equivalents held in the bank or on hand, available for current use. The organization reports their actual results for the quarter they reported non-compliance with the grading criteria. The organization also provides projections for this account which are based on the organization’s financial assumptions.
- Row 2: “Short-Term Investments” are 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. The organization reports their actual results for the quarter they reported non-compliance with the grading criteria. The organization also provides projections for this account which are based on the organization’s financial assumptions.
- Row 3: “HMO Capitation Receivable-Net (collectible within 30 days)” are 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 or fixed periodic payment, determined to be uncollectible during the period. The organization reports their actual results for the quarter they reported non-compliance with the grading criteria. The organization also provides projections for this account which are based on the organization’s financial assumptions.

- Row 4: “HMO Capitation Receivable–Net (collectible beyond 30 days)” are 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 or fixed periodic payment, but do not include risk receivables. The organization reports their actual results for the quarter they reported non-compliance with the grading criteria. The organization also provides projections for this account which are based on the organization’s financial assumptions.
- Row 5: “Non-HMO/Fee-for-Service Receivable–Net” are billings for patient care provided directly by the organization and due from third parties or patient less the amounts accrued for receivables determined to be uncollected during the period. The organization reports their actual results for the quarter they reported non-compliance with the grading criteria. The organization also provides projections for this account which are based on the organization’s financial assumptions.
- Row 6: “HMO Receivable-Net” are gross amounts collectible from HMOs for receivables other than those through a capitated or fixed periodic payment, such as withholds and refunds. The organization reports their actual results for the quarter they reported non-compliance with the grading criteria. The organization also provides projections for this account which are based on the organization’s financial assumptions.
- Row 7: “Risk Pool Receivable–Net” are 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.
- Row 8: “Other Incentive Program Receivables–Net” are 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.
- Row 9: “Secured Affiliate Receivable – Net” are 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.
- Row 10: “Unsecured Affiliate Receivable – Net” are 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 the same terms as equivalent transactions with nonaffiliated entities and which are not past due.
- Row 11: “Other Receivable-Net” are gross amounts from other sources not previously disclosed, less amounts accrued for receivables determined to be uncollectible for the period.
- Row 12: “Other Current Assets” are other current assets including prepayments, supply inventories and other items that are not included in the other current asset categories.
- Row 13: “**Total Current Assets**” is the total of the above listed categories in rows 1-12.

Other Assets: This information is necessary to assist the Department in evaluating the overall assets of the organization when assessing its financial viability. The information is delineated in the following rows to list the organization's other assets not already listed in rows 1-12:

- Row 14: "Long-term Investments" are investments intended to be held for a period longer than twelve months.
- Row 15: "Intangible Assets and Goodwill - Net" are assets of no physical substance; may include goodwill, software, covenants not to compete, patents, copyrights, licenses, franchises, etc., all net of accumulated amortization.
- Row 16: "Risk Pool Receivable (Non-Current)" are amounts which 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.
- Row 17: "Other Incentive Program Receivables (Non-Current)" are amounts collectible for the organization's incentive receivables, net of bad debt allowances.
- Row 18: "Secured Affiliate Receivables-Long-Term" are any secured non-current (over 365 days) accounts receivable from a parent, subsidiary and/or affiliates.
- Row 19: "Unsecured Affiliate Receivables-Long-Term" are any unsecured non-current accounts receivable that is past due from parent, subsidiary and/or affiliate.
- Row 20: "Other Non-Current Assets" are other non-current assets that were not reported in previous categories.
- Row 21: "**Total Other Assets**" total of the above listed categories in rows 14-20.
- Row 22: "**Total Property and Equipment-Net**" is all property, plant, and equipment, net of accumulated depreciation.
- Row 23: "**Total Assets**" is the total of rows 13, 21, and 22.

Current Liabilities: This information is necessary to assist the Department in evaluating the liabilities of the organization when assessing its financial viability and whether the proposed CAP is adequate. This information is delineated in the following rows to list the liabilities of the organization:

- Row 24: "Trade Accounts Payable" are 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" are amounts due to capitated providers (i.e. physicians, medical groups/IPAs, etc.) for medical services rendered to enrollees of the organization.
- Row 26: "Claims Payable (excluding Incurred But Not Reported Claims)" are claims received but not paid, but not including Incurred But Not Reported Claims, pursuant to section 1300.77.4 of the Regulations.
- Row 27: "Incurred But Not Reported Claims" is 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" are 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 29: “Other Medical Liability” are all other medical liabilities due that are not reported in the above categories.
- Row 30: “Loans and Notes Payable (Current)” is the principal amount due on loans and notes payable within one year.
- Row 31: “Amounts Due to Affiliates (Current)” are liabilities owed to affiliates in the normal course of business.
- Row 32: “Other Current Liabilities” are all other current liabilities. Include all items that are not included in the current liability categories.
- Row 33: “**Total Current Liabilities**” is the total of the rows 24-32.

Other Liabilities: This information is necessary to assist the Department in evaluating the liabilities of the organization when assessing its financial viability and whether the proposed CAP is adequate. This information is delineated in the following rows to list other liabilities of the organization not previously listed:

- Row 34: “Loans and Notes Payable (not subordinated) (Long-Term)” is 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)” is the principal amount due on loans and notes that are subordinated, including the current portion.
- Row 36: “Accrued Subordinated Interest Payable” is the accrued interest due on any subordinated loan and/or notes.
- Row 37: “Amounts Due to Affiliates (Long-Term)” are long term liabilities owed to affiliates in the normal course of business.
- Row 38: “Other Long-Term Liabilities” are all other long-term liabilities that are not included above.
- Row 39: “**Total Other Liabilities**” is the total of the liabilities listed in rows 34-38.
- Row 40: “**Total Liabilities**” is the total of the liabilities listed in rows 33 and 39.

Net Worth: This information is necessary to assist the Department in evaluating the net worth of the organization when assessing its financial viability and whether the proposed CAP is adequate. This information is delineated in the following rows detailing the calculations used to determine the net worth of the organization.

- Row 41: “Capital” is the cumulative amount of capital contributions including stock.
- Row 42: “Additional Paid-In Capital” is the excess amount of capital contributions for the period (including paid-in capital over stock par or stated value).
- Row 43: “Retained Earnings (deficit/fund balance)” is the cumulative earnings or deficit from operations, net of reserves and restricted funds.
- Row 44: “Other Net Worth Items” is all other net worth items that are not included above.
- Row 45: “**Total Net Worth**” is the total of Net Worth Categories in rows 41 – 44.
- Row 46: “**Total Liabilities and Net Worth**” is the total of Total Liabilities and Net Worth (row 40 and row 45).

Statement of Net Worth: This information is necessary to assist the Department in evaluating the statement of net worth of the organization when assessing its financial viability and whether the proposed CAP is adequate. This information provides detail to the “net worth” section in the Balance Sheet described above (rows 41- 45). This table provides a detailed analysis on how the values in the Net Worth section are reached, providing the Department a greater understanding of the solvency of the organization. The following rows are required:

- Row 1: “Net Worth Beginning of Period” is the starting value carried over from the previous quarter.
- Row 2: “Audit Adjustments” are any adjustments to the above reported net worth that occurred as a result of an audit.
- Row 3: “Increase (Decrease) in Stock” is any adjustment to the value of the organization’s stock, if any.
- Row 4: “Increase (Decrease) in Additional Paid-In Capital” is any additional capital paid-in to the organization, if any, or any loss of capital paid-in to the organization.
- Row 5: “Increase (Decrease) in Contributed Capital” is any capital contributed or lost to the organization during that period, if any.
- Row 6: “Increase (Decrease) in Retained Earnings” are any other earnings either gained or lost during the period.
- Row 7: “Net Income (Loss)” is the value reported in the Income Statement listed above.
- Row 8: “Distributions to Shareholders” is the value of any distributions to shareholders that occurred during that period and, therefore, reduce the assets available to the organization.
- Row 9: “Changes in Other Net Worth Items” allows the organization to report any other changes to the net worth of an organization during the period.
- Row 10: “**Net Worth End of Period**” is the sum of the changes to net worth at the end of the period.

Income Statement: This information is necessary to assist the Department in evaluating the income of the organization when assessing its financial viability and whether the proposed CAP is adequate. This information is necessary for the organization to demonstrate its financial performance over a specific accounting period. The income and expense information provide the Department clear information on the ability of an organization to maintain solvency.

Revenues: This information is necessary to assist the Department in evaluating the revenues of the organization when assessing its financial viability and whether the proposed CAP is adequate. This information is delineated in the following rows to detail the calculations for the revenue of an organization:

- Row 1: “HMO Revenue” is 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” is 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” is 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 4: “Other Incentive Pool Revenue” is revenues earned from any other incentive pools.
- Row 5: “Other Revenue” is any other source of revenues not listed above.
- Row 6: “**Total Revenue**” is the sum of all revenue categories in rows 1-5.

Expenses: This information is necessary to assist the Department in evaluating the expenses of the organization when assessing its financial viability and whether the proposed CAP is adequate. This information is delineated in the following rows detailing the calculations for the expenses of the organization.

- Row 7: “Physician and Physician Extender - Salary & Benefits” is 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” is 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 9: “Pharmacy Expense” refers to fees incurred by the organization for providing prescription drugs to enrollees.
- Row 10: “Other Medical Expenses (Capitated)” is all other capitated medical professional services that are not reported above.
- Row 11: “Other Medical Expenses (Non-Capitated)” is all other non-capitated medical professional services that are not reported 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**” is the sum of the expenses listed in rows 7 – 12.
- Row 14: “Income (Loss) Before Provision For Income Taxes” is the earnings or loss before taxes, expressed as row 93 minus row 102.
- Row 15: “Income Taxes” is an estimate of taxes levied by the government on income for the organization.
- Row 16: “**Net Income (Loss)**” is the earnings after all expenses and taxes have been deducted.

“STATEMENT OF CASH FLOWS”: This information is necessary to assist the Department in evaluating the cash flows of the organization when assessing its financial viability and whether the proposed CAP is adequate. This information demonstrates the changes in cash flows over the reporting period as classified by operating, investing, and financing activities. It also provides reconciliation and adjustments to net cash provided by operating activities. This information provides the Department clear information on the cash inflows and outflows of the organization.

“CASH FLOW PROVIDED (USED) BY OPERATING ACTIVITIES”: This information is necessary to assist the Department in evaluating the cash flows used by operating activities of the organization when assessing its financial viability and whether the proposed CAP is adequate. This information is delineated in the following rows detailing the calculation of operational cash flows of the organization.

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

“CASH FLOW PROVIDED (USED) BY INVESTING ACTIVITIES”: This information is necessary to assist the Department in evaluating the cash flow used by investing activities of the organization when assessing its financial viability and whether the proposed CAP is adequate. This information is delineated in the following rows detailing the calculation of investing cash flows of the organization:

- Row 10: “Investments” is the amount of cash or cash equivalents an organization receives or uses from the purchase or sale of Investments (non-Trading).
- Row 11: “Property, Plant and Equipment” is the amount of cash or cash equivalents an organization receives or uses from the purchase or sale of Property, Plant, and Equipment.
- Row 12: “Other Long-Term Assets” is the amount of cash or cash equivalents an organization receives or uses from the purchase or sale of Other Long-Term Assets.
- Row 13: **“NET CASH PROVIDED (USED) BY INVESTING ACTIVITIES”** is the amount of cash or cash equivalents an organization receives or uses to pay ongoing investing activities.

“CASH FLOW PROVIDED (USED) BY FINANCING ACTIVITIES”: This information is necessary to assist the Department in evaluating the cash flow provided by the financing

activities of the organization when assessing its financial viability and whether the proposed CAP is adequate. This information is delineated in the following rows detailing the calculation of financing cash flows of the organization:

- Row 14: “Capital or Stock Issuance” is the amount of cash or cash equivalents an organization receives or uses from Capital or Stock Issuance.
- Row 15: “Loans (Affiliates)” is the amount of cash or cash equivalents an organization receives or uses from affiliated loans.
- Row 16: “Loans (Non-Affiliates)” is the amount of cash or cash equivalents an organization receives or uses from non-affiliated loans.
- Row 17: “Dividends Paid” is the amount of cash or cash equivalents an organization uses for dividend payments to shareholders.
- Row 18: “Other Financing Activities” is 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**” is 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**” is the sum of the change in cash or cash equivalents the organization experienced during the reporting period.
- Row 21: “**CASH AND CASH EQUIVALENTS AT BEGINNING OF THE QUARTER**” is the amount of cash and cash equivalents an organization had at the beginning of the reporting period.
- Row 22: “**CASH AND CASH EQUIVALENTS AT END OF THE QUARTER**” is the amount of cash and cash equivalents an organization had at the end of the reporting period. This figure allows the Department to evaluate the net change in an organization’s reserves.

“RECONCILIATION OF NET INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES”: This information is necessary to assist the Department in evaluating the reconciliation of the net income to net cash provided by the operating activities of the organization when assessing its financial viability and whether the proposed CAP is adequate. This information is delineated in the following row detailing the reconciliation of net income to net cash provided by operating activities for the organization:

- Row 23: “Net Income” is the excess or deficiency of total revenues over total expenses. This is used as the baseline for the reconciliation for net cash provided by operating activities.

“ADJUSTMENTS TO RECONCILE NET INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES”: This information is necessary to assist the Department in evaluating the adjustment reconciling the net income to net cash provided by the operating activities of the organization when assessing its financial viability and whether the proposed CAP is adequate. This information is delineated in the following rows detailing the adjustments to reconcile net income cash provided by operating activities of the organization:

- Row 24: “Depreciation and Amortization” is used to adjust depreciation and amortization (non-cash expenses) from net income to determine net cash provided by operating activities.
- Row 25: “Decrease (Increase) In Receivables” is used to adjust changes in receivables from net income to determine net cash provided by operating activities.
- Row 26: “Decrease (Increase) In Prepaid Expenses” is used to adjust changes in prepaid expenses from net income to determine net cash provided by operating activities.
- Row 27: “Decrease (Increase) In Affiliated Receivables” is used to adjust changes in affiliated receivables from net income to determine net cash provided by operating activities.
- Row 28: “Decrease (Increase) In Accounts Payable” is used to 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” is used to 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” is used to 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” is used to determine any other adjustments to net income needed to reconcile to net cash provided by operating activities.
- Row 32: “**TOTAL ADJUSTMENTS**” is the sum of all adjustments to Net Income listed in rows 142-149.
- Row 33: “**NET CASH PROVIDED BY OPERATING ACTIVITIES**” is the amount of cash or cash equivalents an organization receives or uses to pay ongoing operating expenses.

“PROJECTED FINANCIAL GRADING CRITERIA”: This information is necessary for the organization to self-attest to how the organization will become compliant with the Solvency Regulations and to assist the Department in its review of the organization’s CAP. The following information is required:

- Row 1: “Tangible Net Equity” allows the organization to attest to how it will reach positive TNE, as defined in amended section 1300.76, subdivision (c) of the Regulations.
- Row 2: “Required Tangible Net Equity” allows the organization to determine the minimum TNE requirement for the period, as determined in Schedule I.
- Row 3: “Working Capital” allows the organization to attest to how it will reach positive working capital pursuant to section 1300.75.4.2, subdivision (b)(4).
- Row 4: “Cash-to-Claims Ratio” allows the organization to attest to how it will reach positive cash-to-claims ratio pursuant to section 1300.75.4.2, subdivision (b)(5).
- Row 5: “Claims Timeliness Percentage” allows the organization to attest to how it will become compliant with claims payment requirements pursuant to section 1300.75.4.2, subdivision (b)(2).
- Row 6: “IBNR Methodology Both Documented and Used in Estimation of IBNR Liabilities” allows the organization to indicate (yes/no) whether the organization

documented and used estimation of IBNR liabilities pursuant to section 1300.77.2 of the Regulations.

FORMS INCORPORATED BY REFERENCE: REPORTING REQUIREMENTS

Pursuant to Government Code section 11346.3, subdivision (d), the Department has made a finding that the reporting requirements contained in the regulation are necessary for the health, safety, or welfare of the people of the state that the regulation apply to businesses.

IDENTIFICATION OF EACH TECHNICAL, THEORETICAL, AND EMPIRICAL STUDY OR REPORT CONSIDERED

No studies or reports were considered in the drafting of the proposed and amended regulations.

DOCUMENTS RELIED UPON

- Knox-Keene Act, sections 1341, 1341.9, 1344, 1345, 1346, and 1375.4;
- Senate Bill 260 (Stats. 1999, ch. 529 (1999-2000 Reg. Sess. §1);
- Sections 1300.75.4, 1300.75.4.1, 1300.75.4.2, 1300.75.4.5, 1300.75.4.7, 1300.75.4.8, and 1300.76 of Title 28, California Code of Regulations;
- Financial Accounting Standards Board (FASB), Accounting Standards Codification, 310-10-35-7 through 35-11; Practitioner's Publishing Co.'s GAAP Guide 2013, chap. 40, paras. 40.204 and 40.205.);
- The Department's Corrective Action Plan Form, dated May, 2018;
- The Department's Quarterly Financial Survey Reporting Form, dated May, 2018;
- The Department's Annual Financial Survey Reporting Form, dated May, 2018; and
- Centinela Freeman Emergency Medical Associates v. Health Net of California, Inc., (2016) 1 Cal.5th 994.

REASONABLE ALTERNATIVES

The Department invites interested persons to present statements or arguments with respect to alternatives to the proposed regulations and amendments at the above-mentioned hearing or during the written comment period. As part of this process, the Department shall determine that no reasonable alternative considered by the agency or that has otherwise been identified and brought to the attention of the agency would be more effective in carrying out the purpose for which the action is proposed, would be as effective and less burdensome to affected private persons than the proposed action, or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

BENEFITS OF THE REGULATION TO THE HEALTH AND WELFARE OF CALIFORNIA RESIDENTS, WORKER SAFETY, AND THE STATE'S ENVIRONMENT

The proposed regulation is a benefit to the public health and to health plans. It ensures that the regulations are consistent with state statutes. These amendments will clarify the types of

organizations that shall report to the Department and how the Department will review financial solvency. This will strengthen the overall health care delivery system by ensuring that organizations are financially sound and capable of paying claims for the health care services for which they have contracted to assume risk.

ECONOMIC IMPACT

The Department has determined the regulations will not have a significant statewide adverse

The amendment with the most significant substantive economic impact is the increase in financial reserves an organization must maintain under proposed section 1300.76. The proposed requirements for an organization's TNE was reached by examining the requirements placed on a health plan and by examining how such a proposal would impact the health care market. The proposed level balances the need for organizations to have some level of financial reserves to demonstrate solvency while minimizing disparate impact on smaller organizations that may have more difficulty maintaining the required amount. The increase is not expected to be burdensome on affected organizations because they have a year to achieve total compliance. Despite the economic impact as a result of the revised TNE requirement, o

ECONOMIC IMPACT ANALYSIS

Creation or Elimination of Jobs Within the State of California

The amendment to title 28, sections 1300.75.4, 1300.75.4.1, 1300.75.4.2, 1300.75.4.5, 1300.75.4.7, 1300.75.4.8, and 1300.76 are designed to clarify and make specific Health and Safety Code section 1375.4 by:

- Clarifying existing law which requires organizations that contract directly with or otherwise arrange for the health care services of a health plan's enrollees to meet the financial solvency requirements of title 28 and places specific responsibilities on health plans and organizations within their contracts;
- Clarifying that an organization which sub-delegates a portion of its responsibility for the health care services of a health plan to another organization on a capitated or fixed periodic payment basis (sub-delegating organization) shall include in their contracts with a sub-delegated organization the same rights and duties as a health plan;

- Eliminating outdated and obsolete language in favor of revised provisions that better serve enrollees and the industry and ensure financial viability;
- Clarify the financial solvency standards that an organization shall be met and how those calculations shall be made and reported;
- Providing a form to report the required quarterly and annual financial survey reports;
- Streamlining the CAP process so that the Department, health plans, and organizations can reach a final CAP in more efficient time period;
- Providing a form to report the required CAP reports; and
- Clarifying the definition of an organization's positive TNE. The proposed requirements for an organization's positive TNE was reached by examining the requirements placed on a health plan and by examining how such a proposal would impact the health care market. Based on Fiscal Year 2016, the Department's most recent fully reported and analyzed fiscal year, approximately 27 organizations will be noncompliant with the revised TNE requirement. These organizations will incur an average cost of \$670,211 in order to satisfy the updated TNE requirement, for a total of \$18,095,690 spread across approximately 27 organizations. The proposed level balances the need for organizations to have some level of financial reserves to demonstrate solvency while minimizing disparate impact on smaller organizations that may have more difficulty maintaining the required amount. The increase is not expected to be burdensome of affected organizations because they have a year to achieve total compliance. These changes are necessary to protect enrollees' interests in the event of an insolvent organization.

Because the amendments only clarify and make specific the updated laws for the health care industry and impacted enrollees, the Department has determined that these amendments will not significantly affect the creation or elimination of jobs within the State of California. On the contrary, the amendments will benefit persons with jobs in the impacted industry in California by updating obsolete provisions and making clear what is required under the current law and ensure the safety of residents of California by implementing standards that benefit the healthcare marketplace.

Creation of New Businesses or the Elimination of Existing Businesses Within the State of California

The amendment to title 28, sections 1300.75.4, 1300.75.4.1, 1300.75.4.2, 1300.75.4.5, 1300.75.4.7, 1300.75.4.8, and 1300.76 are designed to clarify and make specific Health and Safety Code section 1375.4 by:

- Clarifying existing law which requires organizations that contract directly with or otherwise arrange for the health care services of a health plan's enrollees to meet the financial solvency requirements of title 28 and places specific responsibilities on health plans and organizations within their contracts;
- Clarifying that an organization which sub-delegates a portion of its responsibility for the health care services of a health plan to another organization on a capitated or fixed periodic payment basis (sub-delegating organization) shall include in their contracts with a sub-delegated organization the same rights and duties as a health plan;

- Eliminating outdated and obsolete language in favor of revised provisions that better serve enrollees and the industry and ensure financial viability;
- Clarify the financial solvency standards that an organization shall be met and how those calculations shall be made and reported;
- Providing a form to report the required quarterly and annual financial survey reports;
- Streamlining the CAP process so that the Department, health plans, and organizations can reach a final CAP in more efficient time period;
- Providing a form to report the required CAP reports; and
- Clarifying the definition of an organization's positive TNE. The proposed requirements for an organization's positive TNE was reached by examining the requirements placed on a health plan and by examining how such a proposal would impact the health care market. Based on Fiscal Year 2016, the Department's most recent fully reported and analyzed fiscal year, approximately 27 organizations will be noncompliant with the revised TNE requirement. These organizations will incur an average cost of \$670,211 in order to satisfy the updated TNE requirement, for a total of \$18,095,690 spread across approximately 27 organizations. The proposed level balances the need for organizations to have some level of financial reserves to demonstrate solvency while minimizing disparate impact on smaller organizations that may have more difficulty maintaining the required amount. The increase is not expected to be burdensome of affected organizations because they have a year to achieve total compliance. These changes are necessary to protect enrollees' interests in the event of an insolvent organization.

Because the amendments only clarify and make specific the updated laws for the health care industry and impacted enrollees, the Department has determined that the amendments will benefit persons with jobs in the impacted industry in California by updating obsolete provisions and making clear what is required under the current law and will not impact the creation of new businesses or the elimination of current businesses within the State of California. Businesses will only benefit from having clear and concise guidelines for ensuring their financial viability in California.

Expansion of Businesses Currently Doing Business Within the State of California

The amendment to title 28, sections 1300.75.4, 1300.75.4.1, 1300.75.4.2, 1300.75.4.5, 1300.75.4.7, 1300.75.4.8, and 1300.76 are designed to clarify and make specific Health and Safety Code section 1375.4 by:

- Clarifying existing law which requires organizations that contract directly with or otherwise arrange for the health care services of a health plan's enrollees to meet the financial solvency requirements of title 28 and places specific responsibilities on health plans and organizations within their contracts;
- Clarifying that an organization which sub-delegates a portion of its responsibility for the health care services of a health plan to another organization on a capitated or fixed periodic payment basis (sub-delegating organization) shall include in their contracts with a sub-delegated organization the same rights and duties as a health plan;
- Eliminating outdated and obsolete language in favor of revised provisions that better serve enrollees and the industry and ensure financial viability;

- Clarify the financial solvency standards that an organization shall be met and how those calculations shall be made and reported;
- Providing a form to report the required quarterly and annual financial survey reports;
- Streamlining the CAP process so that the Department, health plans, and organizations can reach a final CAP in more efficient time period;
- Providing a form to report the required CAP reports; and
- Clarifying the definition of an organization's positive TNE. The proposed requirements for an organization's positive TNE was reached by examining the requirements placed on a health plan and by examining how such a proposal would impact the health care market. Based on Fiscal Year 2016, the Department's most recent fully reported and analyzed fiscal year, approximately 27 organizations will be noncompliant with the revised TNE requirement. These organizations will incur an average cost of \$670,211 in order to satisfy the updated TNE requirement, for a total of \$18,095,690 spread across approximately 27 organizations. The proposed level balances the need for organizations to have some level of financial reserves to demonstrate solvency while minimizing disparate impact on smaller organizations that may have more difficulty maintaining the required amount. The increase is not expected to be burdensome of affected organizations because they have a year to achieve total compliance. These changes are necessary to protect enrollees' interests in the event of an insolvent organization.

Because the amendments only clarify and make specific the updated laws for the health care industry and impacted enrollees, the Department has determined that the amendments will not impact the expansion of business within the State of California but in fact will benefit the impacted industry in California by updating obsolete provisions and making clear what is required under the current law in the Knox-Keene Act.

The Benefits to the Health and Welfare of California Residents, Worker Safety, and the State's Environment

The amendment to title 28, sections 1300.75.4, 1300.75.4.1, 1300.75.4.2, 1300.75.4.5, 1300.75.4.7, 1300.75.4.8, and 1300.76 are designed to clarify and make specific Health and Safety Code section 1375.4 by:

- Clarifying existing law which requires organizations that contract directly with or otherwise arrange for the health care services of a health plan's enrollees to meet the financial solvency requirements of title 28 and places specific responsibilities on health plans and organizations within their contracts;
- Clarifying that an organization which sub-delegates a portion of its responsibility for the health care services of a health plan to another organization on a capitated or fixed periodic payment basis (sub-delegating organization) shall include in their contracts with a sub-delegated organization the same rights and duties as a health plan;
- Eliminating outdated and obsolete language in favor of revised provisions that better serve enrollees and the industry and ensure financial viability;
- Clarify the financial solvency standards that an organization shall be met and how those calculations shall be made and reported;
- Providing a form to report the required quarterly and annual financial survey reports;

- Streamlining the CAP process so that the Department, health plans, and organizations can reach a final CAP in more efficient time period;
- Providing a form to report the required CAP reports; and
- Clarifying the definition of an organization's positive TNE. The proposed requirements for an organization's positive TNE was reached by examining the requirements placed on a health plan and by examining how such a proposal would impact the health care market. Based on Fiscal Year 2016, the Department's most recent fully reported and analyzed fiscal year, approximately 27 organizations will be noncompliant with the revised TNE requirement. These organizations will incur an average cost of \$670,211 in order to satisfy the updated TNE requirement, for a total of \$18,095,690 spread across approximately 27 organizations. The proposed level balances the need for organizations to have some level of financial reserves to demonstrate solvency while minimizing disparate impact on smaller organizations that may have more difficulty maintaining the required amount. The increase is not expected to be burdensome of affected organizations because they have a year to achieve total compliance. These changes are necessary to protect enrollees' interests in the event of an insolvent organization.

Because the amendments only clarify and make specific the updated laws for the health care industry and impacted enrollees, the Department has determined that this amendment will not significantly affect California residents, worker safety or the state's environment and in fact, will benefit California residents by securing their access to healthcare by amending regulations that ensure the viability of the healthcare marketplace.

Benefits to the Health and Welfare of California Residents

The amendment to title 28, sections 1300.75.4, 1300.75.4.1, 1300.75.4.2, 1300.75.4.5, 1300.75.4.7, 1300.75.4.8, and 1300.76 are designed to clarify and make specific Health and Safety Code section 1375.4 by:

- Clarifying existing law which requires organizations that contract directly with or otherwise arrange for the health care services of a health plan's enrollees to meet the financial solvency requirements of title 28 and places specific responsibilities on health plans and organizations within their contracts;
- Clarifying that an organization which sub-delegates a portion of its responsibility for the health care services of a health plan to another organization on a capitated or fixed periodic payment basis (sub-delegating organization) shall include in their contracts with a sub-delegated organization the same rights and duties as a health plan;
- Eliminating outdated and obsolete language in favor of revised provisions that better serve enrollees and the industry and ensure financial viability;
- Clarify the financial solvency standards that an organization shall be met and how those calculations shall be made and reported;
- Providing a form to report the required quarterly and annual financial survey reports;
- Streamlining the CAP process so that the Department, health plans, and organizations can reach a final CAP in more efficient time period;
- Providing a form to report the required CAP reports; and

- Clarifying the definition of an organization's positive TNE. The proposed requirements for an organization's positive TNE was reached by examining the requirements placed on a health plan and by examining how such a proposal would impact the health care market. Based on Fiscal Year 2016, the Department's most recent fully reported and analyzed fiscal year, approximately 27 organizations will be noncompliant with the revised TNE requirement. These organizations will incur an average cost of \$670,211 in order to satisfy the updated TNE requirement, for a total of \$18,095,690 spread across approximately 27 organizations. The proposed level balances the need for organizations to have some level of financial reserves to demonstrate solvency while minimizing disparate impact on smaller organizations that may have more difficulty maintaining the required amount. The increase is not expected to be burdensome of affected organizations because they have a year to achieve total compliance. These changes are necessary to protect enrollees' interests in the event of an insolvent organization.

The ultimate benefits to the health and welfare of residents of California from these amendments are increased protection of the public health and safety, as well as increased transparency in business and business practices. California residents will benefit by securing their access to healthcare by amending regulations that ensure the viability of the healthcare marketplace.