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|---|---|
| Policy: | FF.3001 |
| Title: | **Financial Reporting** |
| Department: | Finance |
| Section: | Not Applicable |
| *CEO Approval*: | */s/ Michael Hunn 08/08/2024* |
| Effective Date: | 01/01/2007 |
| Revised Date: | 08/01/2024 |
| Applicable to: | ☒ Medi-Cal<br>☒ OneCare<br>☐ PACE<br>☐ Administrative |

## I. PURPOSE

This policy outlines the process by which CalOptima Health monitors the timely submission of required financial reports by Health Networks.

## II. POLICY

A. A Health Network shall submit required financial information to CalOptima Health in accordance with the Health Network Contract, and the terms and conditions of this policy.

B. CalOptima Health shall use such financial information to monitor the financial viability and stability of a Health Network and to ensure that appropriate resources are available to provide Covered Services to Members.

C. A Health Network shall submit the following reports to CalOptima Health according to the schedule and in the manner set forth in this policy.

1. Physician Hospital Consortium (PHC) Reporting Due Date Summary

| Financial Reports | Due Date |
|---|---|
| a. Quarterly Total Business Reports (Financial Statements) | Forty-five (45) calendar days after the end of the quarter. |
| b. Annual Audited Financial Statements | One hundred twenty (120) calendar days after the end of the organization's fiscal year. |
| c. Medical Loss Ratio (MLR) Report | Interim: Six (6) months ended June 30 due August 15, and twelve (12) months ended December 31 due February 15. |
| | Final: Twelve (12) months ended December 31 due by June 30. |
| d. Risk Bearing Organization (RBO) Financial Survey Reports | Quarterly: Forty-five (45) calendar days after the end of the quarter. |
| | Annual: One hundred fifty (150) calendar days after the end of the organization's fiscal year. |

2. PHC Financial Report Details

    a. Quarterly Total Business Reports (Financial Statements)

        i. Each PHC partner shall submit their respective year-to-date financial statements to CalOptima Health forty-five (45) calendar days after the end of each quarter.

        ii. Financial statements shall include:

            a) Balance sheet;

            b) Statement of revenues and expenses;

            c) Statement of cash flows; and

            d) Related disclosures.

    b. Annual Audited Financial Statements

        i. Each PHC partner shall submit their audited financial statements, including any letters to management, within one hundred twenty (120) calendar days after the end of the organization's fiscal year.

        ii. If a PHC partner is part of a larger entity, the PHC partner shall submit the consolidated corporate audited financial statements to CalOptima Health.

        iii. Each PHC partner shall submit the following financial statements:

            a) Balance sheet;

            b) Statement of revenues and expenses;

            c) Statement of cash flows;

            d) Related notes and disclosures; and

            e) Audit opinion.

    c. Medical Loss Ratio (MLR) Report

        i. A Primary Physician Group shall utilize the most current Annual Financial Reporting Form (AFRF), provided by CalOptima Health, to report the MLR of the PHC. PHC submissions shall include both Physician and Primary Hospital data.

        ii. A Primary Physician Group shall submit interim AFRF reports to CalOptima Health as follows:

            a) For the period six (6) months ended June 30, due August 15; and

            b) For the period of twelve (12) months ended December 31, due February 15.

iii. A Primary Physician Group shall submit a final AFRF report (if changed from the second interim submission above) to CalOptima Health as follows:

a) For the period of twelve (12) months ended December 31, due June 30 (one hundred eighty (180) calendar days after the end of the calendar year).

d. Risk Bearing Organization (RBO) Financial Survey Reports

i. Quarterly: A Primary Physician Group shall submit a copy of the Department of Managed Health Care (DMHC) RBO Quarterly Financial Survey Report, pursuant to Title 28, California Code of Regulations, Section 1300.75.4.3, to CalOptima Health forty-five (45) calendar days after the end of each quarter.

ii. Annual: A Primary Physician Group shall submit a copy of the DMHC RBO Annual Financial Survey Report, pursuant to Title 28, California Code of Regulations, Section 1300.75.4.3, to CalOptima Health within one hundred fifty (150) calendar days of the close of the Primary Physician Group's fiscal year.

3. Shared Risk Group (SRG) Reporting Due Date Summary

| **Financial Reports** | **Due Date** |
|---|---|
| a. Quarterly Total Business Reports (Financial Statements) | Forty-five (45) calendar days after the end of the quarter. |
| b. Annual Audited Financial Statements | One hundred twenty (120) calendar days after the end of the organization's fiscal year. |
| c. Medical Loss Ratio (MLR) Report | Interim: Six (6) months ended June 30 due August 15, and twelve (12) months ended December 31 due February 15. |
| | Final: Twelve (12) months ended December 31 due by June 30. |
| d. Risk Bearing Organization (RBO) Financial Survey Reports | Quarterly: Forty-five (45) calendar days after the end of the quarter. |
| | Annual: One hundred fifty (150) calendar days after the end of the organization's fiscal year |

4. SRG Financial Report Details

a. Quarterly Total Business Reports (Financial Statements)

i. An SRG shall submit their respective year-to-date financial statements to CalOptima Health forty-five (45) calendar days after the end of each quarter.

ii. Financial statements shall include:

a) Balance sheet;

b) Statement of revenues and expenses;

c) Statement of cash flows; and

d) Related disclosures.

b. Annual Audited Financial Statements

i. An SRG shall submit its audited financial statements, including any letters to management, within one hundred twenty (120) calendar days after the end of the organization's fiscal year.

ii. If an SRG is part of a larger entity, the SRG shall submit the consolidated corporate audited financial statements to CalOptima Health.

iii. An SRG shall submit the following financial statements:

a) Balance sheet;

b) Statement of revenues and expenses;

c) Statement of cash flows;

d) Related notes and disclosures; and

e) Audit opinion.

c. Medical Loss Ratio (MLR) Report

i. An SRG shall utilize the most current AFRF, provided by CalOptima Health, to report the MLR of the SRG. SRG submissions may include physician data only.

ii. An SRG shall submit interim AFRF reports to CalOptima Health as follows:

a) For the period six (6) months ended June 30, due August 15; and

b) For the period of twelve (12) months ended December 31, due February 15.

iii. An SRG shall submit a final AFRF report (if changed from the second interim submission above) to CalOptima Health as follows:

a) For the period of twelve (12) months ended December 31, due June 30 (one hundred eighty (180) calendar days after the end of the calendar year).

d. Risk Bearing Organization (RBO) Financial Survey Reports

i. Quarterly: An SRG shall submit a copy of the DMHC RBO Quarterly Financial Survey Report, pursuant to Title 28, California Code of Regulations, Section 1300.75.4.3, to CalOptima Health forty-five (45) calendar days after the end of each quarter.

ii. Annual: An SRG shall submit a copy of the DMHC RBO Annual Financial Survey Report, pursuant to Title 28, California Code of Regulations, Section 1300.75.4.3, to CalOptima Health within one hundred fifty (150) calendar days of the close of the SRG's fiscal year.

5. Health Maintenance Organization (HMO) Reporting Due Date Summary

| Financial Reports | Due Date |
|---|---|
| a. Annual Audited Financial Statements | Submit to the DMHC by DMHC established due date. |
| b. Medical Loss Ratio (MLR) Report | Interim: Six (6) months ended June 30 due August 15, and twelve (12) months ended December 31 due February 15. |
| | Final: Twelve (12) months ended December 31 due by June 30. |

6. HMO Financial Report Details

   a. Annual Audited Financial Statements

      i. An HMO shall submit their annual audited financial statements to the DMHC in accordance with the requirements and due dates established by the DMHC.

   b. Medical Loss Ratio (MLR) Report

      i. An HMO shall utilize the most current Annual Financial Reporting Form (AFRF), provided by CalOptima Health, to report the MLR of the HMO. HMO submissions shall include both physician and hospital data.

      ii. An HMO shall submit interim AFRF reports to CalOptima Health as follows:

         a) For the period six (6) months ended June 30, due August 15; and

         b) For the period of twelve (12) months ended December 31, due February 15.

      iii. An HMO shall submit a final AFRF report (if changed from the second interim submission above) to CalOptima Health as follows:

         a) For the period of twelve (12) months ended December 31, due June 30 (one hundred eighty (180) calendar days after the end of the calendar year).

D. CalOptima Health may request that a Health Network provide additional data or may modify the form, content, instructions, and timetables for the collection and reporting of data as set forth in the Health Network Contract and this policy, subject to the provision of adequate notice to the Health Network.

E. CalOptima Health may assess a late fee or other form of Sanction, or issue a Corrective Action Plan (CAP), on a Health Network for failure to comply with this policy in accordance with CalOptima Health Policy HH.2002: Sanctions.

## III. PROCEDURE

A. A Health Network shall submit financial reports electronically to CalOptima Health's Secure File Transfer Protocol (SFTP) site, within the deadlines specified in this policy. The reports are automatically routed to CalOptima Health's Finance Department.

B. If a Health Network fails to submit a report or fails to submit a report on a timely basis, the CalOptima Health Office of Compliance may issue a Sanction in accordance with CalOptima Health Policy HH.2002: Sanctions.

## IV. ATTACHMENT(S)

A. Annual Financial Reporting Form (AFRF) for PHC and SRG
B. Annual Financial Reporting Form (AFRF) for HMO
C. Health Network MLR Guidelines for PHC and SRG
D. Health Network MLR Guidelines for HMO
E. Health Network IBNR Guidance

## V. REFERENCE(S)

A. Health Network Contract
B. CalOptima Health Policy HH.2002: Sanctions
C. Title 28, California Code of Regulations, §§ 1300.75.4 - 1300.75.4.8

## VI. REGULATORY AGENCY APPROVAL(S)

| Date | Regulatory Agency | Response |
|---|---|---|
| 05/20/2016 | Department of Health Care Services (DHCS) | Approved by Submitted |
| 06/26/2023 | Department of Health Care Services (DHCS) | Approved by Submitted |

## VII. BOARD ACTION(S)

| Date | Meeting |
|---|---|
| 11/18/2021 | Regular Meeting of the CalOptima Health Finance and Audit Committee |
| 12/20/2021 | Special Meeting of the CalOptima Health Board of Directors |

## VIII. REVISION HISTORY

| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Effective | 06/01/2001 | FF.1103 | Monitoring Financial Reporting | Medi-Cal |
| Revised | 04/01/2003 | FF.1103 | Monitoring Financial Reporting | Medi-Cal |
| Revised | 01/01/2007 | FF.3001 | Financial Reporting | Medi-Cal |
| Revised | 01/01/2008 | FF.3001 | Financial Reporting | Medi-Cal |
| Revised | 08/01/2008 | FF.3001 | Financial Reporting | Medi-Cal |
| Revised | 01/01/2016 | FF.3001 | Financial Reporting | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 03/01/2017 | FF.3001 | Financial Reporting | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 12/01/2017 | FF.3001 | Financial Reporting | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 01/01/2019 | FF.3001 | Financial Reporting | Medi-Cal<br>OneCare<br>OneCare Connect |

| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Revised | 10/01/2019 | FF.3001 | Financial Reporting | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 06/01/2020 | FF.3001 | Financial Reporting | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 12/20/2021 | FF.3001 | Financial Reporting | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 05/01/2022 | FF.3001 | Financial Reporting | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 07/01/2023 | FF.3001 | Financial Reporting | Medi-Cal<br>OneCare |
| Revised | 08/01/2024 | FF.3001 | Financial Reporting | Medi-Cal<br>OneCare |

## IX. GLOSSARY

| Term | Definition |
|---|---|
| Corrective Action Plan (CAP) | A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. First Tier, Downstream and Related Entities (FDRs) and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators. |
| Department of Managed Health Care (DMHC) | The State Agency that responsible for licensing and regulating health care services plans/health maintenance organizations in accordance with the Knox Keene Health Care Service Plan Act of 1975 and as subsequently amended. |
| Health Maintenance Organization (HMO) | A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code. |
| Health Network | For the purposes of this policy, a Physician Hospital Consortium (PHC), physician group under a shared risk contract, or HMO that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network, either directly or through the use of subcontractors and downstream subcontractors that may be subject to the terms of this policy. |
| Health Network Contract | For purposes of this policy, the applicable written instrument between CalOptima Health and a Health Network, for the purposes of providing delegated services to assigned Members. Health Network Contracts include the Contract for Health Care Services, and the Medicare Advantage Service Agreement, including any and all amendments thereto. |
| Incurred But Not Reported (IBNR) | IBNR means "incurred but not reported," and refers to an estimate of claims that have been incurred for medical services provided, but for which claims have not yet been received by the Health Network. |
| Medical Loss Ratio (MLR) | The percentage calculated by dividing the Health Network's total medical costs paid on behalf of CalOptima Health Members by the total revenue received from CalOptima Health. Health Network medical costs would include incurred claims, expenditures for activities that improve healthcare quality, and fraud reduction activities. |
| Member | A beneficiary enrolled in a CalOptima Health program. |
| Physician Hospital Consortium (PHC) | A physician group or physician groups contractually aligned with at least one (1) hospital to provide Medi-Cal services to a common set of assigned Members, as described in CalOptima Health's Contract for Health Care Services. |
| Primary Hospital | A hospital contracted with CalOptima Health on a capitated and delegated basis as the hospital partner of a Physician Hospital Consortium (PHC). |
| Primary Physician Group | A physician group contracted with CalOptima Health on a capitated and delegated basis as the physician partner of a Physician Hospital Consortium (PHC). |

| Term | Definition |
|---|---|
| Risk Bearing Organization (RBO) | A professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, or another lawfully organized group of physicians that;<br><br>1. Delivers, furnishes, or otherwise arranges for or provides health care services; and<br>2. Does all the following:<br>a. Contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees;<br>b. Receives compensation for those services on a capitated or fixed periodic payment basis; and<br>c. Is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of a health care service plan that are covered under the capitation payment made by the plan to the risk bearing organization. |
| Sanction | An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs. |
| Shared Risk Group (SRG) | A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima Health as the responsible partner for facility services. |