
**RITE CARE AND RHODY HEALTH PARTNERS FINANCIAL REPORTING
PROGRAM
POLICY AND PROCEDURES**

I. OBJECTIVE:

The objective of the RItE Care and Rhody Health Partners Health Plan Financial Reporting Program (FRP) is to monitor the financial performance and solvency of each RItE Care and Rhody Health Partners contracted Health Maintenance Organization (HMO), in an effort to ensure that the HMO is financially stable and can be expected to be able to fulfill its obligations to its health care providers, and therefore to its RItE Care and Rhody Health Partners members, the RItE Care and Rhody Health Partners programs, and the State of Rhode Island.

II. OVERVIEW OF THE FRP:

The FRP is designed to be applied in conjunction with the rules, regulations and requirements of the Rhode Island Department of Business Regulation (DBR), which is responsible for the licensing and oversight of the HMOs in the State.

In addition, all Federal, and any other jurisdictional requirements that apply to the financial soundness, stability, and solvency of the contracted HMOs, are made part of this FRP by this reference.

The FRP is being developed in cooperation with the HMOs in an effort to build on existing reporting requirements, abilities, and formats, so that duplication and excess labor and paperwork is kept at a minimum.

The FRP is based on electronic, as well as hard copy reporting to allow for an ease of analysis and comparison as well as certification of the data being reported.

The FRP is made-up of four main segments:

- Reporting
- Review and Analysis
- Audit
- Corrective Action

These four segments work together to provide a comprehensive reporting, review and action program that will meet the requirements of the RItE Care and the Rhody Health Partners programs.

III. REPORTING:

The starting point of the FRP is the reporting of financial data and other data that may have an impact on the financial position or stability of the HMOs.

The base financial reporting document is the quarterly and annual NAIC “Orange Forms” that are prepared for submission to the DBR. These reports will be required to be submitted to the Center for Child and Family Health (CCFH) at the same time that they are reported to the DBR. In addition, sub-and additional schedules that relate to both Rhody Health Partners and overall operations will also be required to be submitted to CCFH at the same time.

Any request for variance from the reporting requirements contained in the FRP must be submitted in writing to the Administrator of CCFH prior to the due date of the specified report, and if accepted, must be confirmed in writing by the Administrator of CCFH to the HMO.

A. Annual Reports

The requirements for submission of the annual “Orange Form” and annual Reports to CCFH include that:

1. The reports must be based on the HMO’s annual financial statement that has been certified by an independent public accountant.
2. The audited and certified annual financial statement must be provided in full with opinion and notes. This statement must cover the entity that is contracted with the State of Rhode Island, or encompass that entity in the parent corporation’s statement which must then be submitted in full.
3. A full copy of any management letter from the independent public accountant prepared with respect to the audit performed and certification of the financial statement. The management letter must cover the same entity that the certified financial statement submitted under item 2 covers.
4. A copy of the HMO’s Annual Report to owners, shareholders, members, cooperators or others.
5. The full report must be submitted no later than the first day of March and cover the full preceding calendar year. If the audited financial statements are unavailable on March 1st, the required reports must still be submitted by March first based on preliminary internal financial statements. In all cases, the final reports based on the audited and certified financial statements must be submitted by the first day of May.
6. The “Orange Form” must be properly certified as required by DBR.
7. The report must be provided in printed form and in the electronic format as prescribed and provided by CCFH.

8. The annual report must include a full and detailed analysis of current IBNR and RBUC reserves as well as a detailed “look back” for the year as defined in Section 2.15.06 of the Health Plan Contract.
9. The reports on uncovered and covered expenses or actuarial certification, as required to be submitted to DBR must also be provided to CCFH at the time of submission to DBR.

B. Quarterly Reports

Quarterly submission of the “Orange Forms” and a quarterly report to CCFH is required. These submission require that:

1. The three quarterly reports must be submitted to CCFH within forty-five (45) days of the completion of the calendar quarter, i.e.: forty-five days after March 31st, June 30th, and September 30th.
2. The reports must be based on the HMO’s internal financial statements for the applicable quarter with appropriate modifications to meet DBR requirements.
3. The quarterly reports must include a full and detailed analysis of IBNR and RBUC reserves as defined in Section 2.15.06 of the Health Plan Contract.
4. A provider Risk Pool or Risk sharing analysis, if applicable, with year-end settlement projection and analysis.
5. A claims lag report detailing by type of claim the average time lags:
 - a. From date of service to date of claim receipt
 - b. From date of claim receipt to date of payment

C. Financial Statement Reviews

CCFH may conduct monthly HMO on-site reviews of internal financial statements with the financial staffs of each HMO. Initially, these reviews will be frequent until CCFH is comfortable with the financial performance and solvency of each HMO. Once CCFH is comfortable with the financial performance and solvency of each HMO, the on-site reviews will decrease in frequency. Internal HMO financial statements will not be submitted to CCFH on a routine basis.

D. Additional Reports

Additional reports may be required by CCFH at any time as the result of:

1. Special circumstances or events
2. Special studies desired by CCFH
3. The review and analysis of reports submitted to CCFH
4. Any audits conducted by CCFH or other regulatory agency

5. Significant changes in financial position or performance by an HMO

IV. REVIEW AND ANALYSIS:

The review and analysis of all reporting will be performed by CCFH with additional information provided by the respective HMO as required. The review and analysis will include the use of:

A. NAIC Insurance Regulatory Information System (IRIS)

1. Profitability
2. Liquidity
3. Capital Structure
4. Other ratios

B. The regulations and guidelines of the State of Rhode Island Office of the Health Insurance Commissioner

C. The NAIC Accounting Practices and Procedures Manual

D. Industry norms – comparison to regional and national HMO data for comparable HMOs

V. AUDIT AND FINANCIAL REVIEW:

A. Annual Financial Review:

CCFH will conduct, or cause to be conducted, an annual on-site financial review at each HMO. These reviews will be performed in order to determine and verify the financial stability of each HMO. The financial review will be based on, but not limited to, a financial review questionnaire that will be provided to the HMO prior to the on-site review. The questionnaire will focus on:

1. Solvency issues
2. Contract requirements
3. Financial statement review
4. TPL activity review
5. Reinsurance activity review
6. Insolvency protection review

B. Audit

As specified in the RIte Care contract and the Rhody Health Partners contract amendment, DHS retains the right to conduct audit functions. These audit functions may be conducted upon reasonable notification to the HMO. The audits will focus on any matters related to:

1. Invoicing by the HMO for provisions of services
2. Payments to the HMO by the Department of Human Services
3. Compliance with the terms of the RIte Care and Rhody Health Partners contract amendment