Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814
Phone: 916-324-8176 | Fax: 916-255-5241
www.DMHC.ca.gov

RISK-BEARING ORGANIZATION (RBO) QUESTIONNAIRE

Please complete the following:

New request for DMHC RBO Number: Yes ☐ No ☐

Other request: _____

General Information:

Provider Organization Legal Name: _____

Provider Organization DBA: _____

Address of Provider Organization: _____

Telephone number of Provider Organization: _____

Name of Principal Officer: _____

E-mail address of Principal Officer: _____

Telephone number of Principal Officer: _____

Name of Finance Contact: _____

E-mail address of Finance Contact: _____

Telephone number of Finance Contact: _____

Management Service Organization (MSO) Contact: _____

E-mail address of MSO Contact: _____

Telephone number of MSO Contact: _____

Federal Identification Number: _____

Secretary of State – Corporation Number: _____

Is your organization claiming that it is exempt from the reporting obligations set forth in obligations set forth in section 1300.75.4.2 of title 28 of the California Code of Regulations? Yes ☐ No ☐

If you are claiming exempt status, generally describe the business model and the ownership structure of the provider organization. State the basis upon which the provider organization has determined that it is not included in the definition of a risk-bearing organization (RBO) set forth in section 1375.4(g)(1) of the California Health and Safety Code.

_____
_____
_____
_____
_____

Regardless of whether you are claiming an exempt status, please answer the following questions:

1. Is your organization a professional medical corporation? Yes ☐ No ☐
2. Is your organization another form of corporation controlled by physicians and surgeons? Yes ☐ No ☐
3. Is your organization a medical partnership? Yes ☐ No ☐
4. Is your organization a medical foundation exempt from licensure pursuant to subdivision (l) of Section 1206? Yes ☐ No ☐
5. Is your organization another lawfully organized group of physicians that deliver, furnish, or otherwise arrange for or provide health care services? Yes ☐ No ☐
6. Is your organization an individual? Yes ☐ No ☐
7. Is your organization a health care service plan? Yes ☐ No ☐
8. Does your organization contract, or intend to contract, directly with a health care service plan and/or RBO? Yes ☐ No ☐
   If so, please list the contracting health care service plan(s)/RBO(s):
   _____
9. Does your organization arrange for, or intend to arrange for, health care services for the health care service plan/RBO's subdelegated enrollees, which are not delivered or furnished directly by the organization? Yes ☐ No ☐
10. Does your organization receive compensation, or intend to receive compensation, for those services on a capitated basis? Yes ☐ No ☐
11. Does your organization receive compensation, or intend to receive compensation, for those services on a fixed periodic payment basis? Yes ☐ No ☐

12. Does your organization receive capitation or fixed periodic payments, or intend to receive capitation or fixed periodic payments, for health care services, which are not directly delivered or furnished by the organization? Yes ☐ No ☐

13. Is your organization responsible, or intend to be responsible for the processing and payment of claims (either directly or under any contractual arrangement) made by providers for services rendered on behalf of a health care service plan that are covered under capitation or fixed periodic payments made by the plan to the organization? Yes ☐ No ☐

14. Does your organization and the contracting health care service plan file consolidated financial statements with the Department? Yes ☐ No ☐

15. If your organization contracts with one health care service plan, are your organization's maximum potential expenses for providing or arranging for health care services limited to no more than 115% of the organization's potential revenue from providing or arranging for contracted services? Yes ☐ No ☐

(Question 15 is only applicable if your organization contracts, or intends to contract with only one health care service plan)

16. What is the expected number of enrollees? _____

17. What is the anticipated percentage of lives under the risk arrangements for each line of business (must total to 100%)?

    Medicare _____

    Medi-Cal _____

    Commercial _____

18. When is the organization expected to receive the enrollment? _____

19. What is the organization's service area (list counties)? _____

20. What is the organization's fiscal year-end date (month, day)? _____

21. Attach the organization chart.

22. Attach the organization's California Articles of Incorporation.

23. When does your organization anticipate filing financial reports with the DMHC?

    _____

I certify (or declare) that the above information therein is true and correct to the best of my knowledge and belief.

Printed Name: _____

Signature: _____

Title: _____

Date: _____