DEPARTMENT OF MANAGED HEALTH CARE
TITLE 28

PROPOSED REGULATIONS

For Data Collection, Disclosure Language, Grading/Reviewing and Corrective Action
For Risk-Bearing Organizations

Amending Regulations 1300.75.4 and 1300.75.4.5, and adopting sections 1300.75.4.2, 1300.75.4.4, 1300.75.4.7 and 1300.75.4.8 of title 28, California Code of Regulations, to read:

§ 1300.75.4. Definitions

As used in these Ssolvency Rregulations:

(a) "External party" means the Department of Managed Health Care's ~~or its~~ designated agent, which may be ~~an outside entity or person contracted~~ contracted or appointed to fulfill the functions stated in these Ssolvency Rregulations. Whenever these Ssolvency Rregulations reference ~~means~~ the Department of Managed Health Care ~~or its designated agent, which may be an outside entity or person contracted by the Department of Managed Health Care to fulfill the stated function.~~ that reference means the Department of Managed Health Care (Department) or the external party.

(b) "Organization" means a risk-bearing organization as defined in ~~subdivision (g) of~~ Health and Safety Code ~~S~~section 1375.4(g).

(c) "Plan" means full-service health care service plan, as defined by Health and Safety Code ~~S~~section 1345(f).

(d) "Risk arrangement" ~~shall include~~ is defined to include both "risk-sharing arrangement" and "risk-shifting arrangement," which are defined as follows:

(1) "Risk-sharing arrangement" means any compensation arrangement between an organization and a plan under which ~~both~~ the organization and the plan share ~~the potential for~~ a risk of financial loss~~or gain in excess of five percent (5%) of the organization's annual capitation revenue.~~

(2) "Risk-shifting arrangement" means a contractual arrangement between an organization and a plan under which the plan pays the organization on a fixed, periodic, or capitated basis, and the financial risk for the cost of services provided pursuant to the contractual arrangement is assumed by the organization.

(e) "Solvency Regulations" means California Code of Regulations, ~~T~~title 28, sections 1300.75.4 through 1300.75.4.8.~~1300.75.4.6~~

(f) “Cash-to-claims ratio” is an organization’s cash and marketable securities divided by the organization’s unpaid claims (claims payable and incurred but not reported [IBNR] claims) liability.

(g) “Corrective action plan" (CAP) means a plan reflected in a document containing requirements for correcting and monitoring an organization's efforts to correct any financial solvency deficiencies in the Grading Criteria or other financial deficiencies, determined through the external party’s review or audit process, indicating that the organization may lack the capacity to meets its contractual obligations consistent with the requirements of section 1300.70(b)(2)(H)(1) of title 28, California Code of Regulations.

(h) “Grading Criteria” means the four grading/reviewing criteria specified in Health and Safety Code section 1375.4(b)(1)(A)(i), (ii), (iii), and (iv) and the cash-to-claims ratio as defined in subsection (f) above.

Authority: Sections 1344 and 1375.4, Health and Safety Code.
Reference: Section 1375.4, Health and Safety Code.

§ 1300.75.4.2. Organization Information

Every contract involving a risk arrangement between a plan and an organization shall require the organization to do the following:

(a) Maintain at all times cash and marketable securities in an amount equal to or greater than the organization’s total unpaid claims liability.(b) Quarterly Financial Survey. For each quarter beginning on or after October 1, 2004, (for an organization that begins a fiscal quarter on October 1, 2004, the first submission is due by February 15, 2005), submit to the external party, not more than forty-five (45) days after the close of each quarter of the fiscal year, a quarterly financial survey report in an electronic format to be supplied by the Department of Managed Health Care (Department) pursuant to section 1300.41.8 of title 28, California Code of Regulations, containing all of the following:

(1) For organizations serving at least 10,000 covered lives under all risk arrangements as of December 31 of the preceding calendar year:

(A) Financial survey report (including a balance sheet, an income statement, and a statement of cash flows), or in the case of a nonprofit entity comparable financial statements and supporting schedule information (including but not limited to aging of receivable information), reflecting the results of operations for the immediately preceding quarter, prepared in accordance with generally accepted accounting principles (GAAP) and the identification of the individual or office in the organization designated to receive public inquiries. Financial survey reports of an organization required pursuant to these rules shall be on a combining basis with an affiliate, if the organization or such affiliate is legally or contractually dependent upon the other for the payment of claims for health care services to enrollees. Any affiliated entity included in this report shall be separately

identified. For the purposes of this section, an organization's use of a "sponsoring organization" arrangement to reduce its liabilities for the purposes of calculating tangible net equity and working capital shall not be construed to automatically create a legal or contractual obligation to pay claims for health care services for enrollees.

(B) A statement as to what percentage of completed claims the organization has timely reimbursed, contested, or denied during the quarter in accordance with the requirements of Health and Safety Code sections 1371, and 1371.35, section 1300.71 of title 28 of the California Code of Regulations, and any other applicable state and federal laws and regulations. If less than 95% of all complete claims have been reimbursed, contested or denied on a timely basis, the statement shall be accompanied by a report that describes the reasons why the claims adjudication process is not meeting the requirements of applicable law, any action taken to correct the deficiency, and any results of that action. This claims payment report is for the purpose of monitoring the financial solvency of the organization and is not intended to change or alter existing state and federal laws and regulations relating to claims payment timeliness.

(C) A statement as to whether or not: (i) the organization has estimated and documented, on a monthly basis, its liability for IBNR claims, pursuant to a method specified in section 1300.77.2, and (ii) the estimates are the basis for the quarterly financial survey report submitted under these Solvency Regulations. If the estimated and documented liability has not met the requirements of section 1300.77.2 in any way, a statement shall be included in the quarterly financial survey report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, the action taken to correct the deficiency, and the results of that action. An organization failing to estimate and document, on a monthly basis, its liability for IBNR claims or maintaining its books and records on a cash accounting basis shall be deemed to have failed to maintain, at all times, positive tangible net equity (TNE) and positive working capital as set forth in subsection (D) below.

(D)(i) A statement as to whether or not the organization has at all times during the quarter maintained positive TNE, as defined in section 1300.76(e) of title 28 California Code of Regulations; and has at all times during the quarter maintained positive working capital, calculated in a manner consistent with GAAP. If either the required TNE or the required working capital has not been maintained at all times, a statement shall be included in the quarterly financial survey report that describes in detail the following, with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

(ii) The organization may reduce its liabilities for purposes of calculating its TNE and working capital in a manner allowed by Health and Safety Code section 1375.4(b)(1)(B) so long as the sponsoring organization has filed with the Department: (1) its audited annual financial statements within 120 days of the end of the sponsoring organization's fiscal year and (2) a copy of the written guarantee meeting the requirements of Health and Safety Code section 1375.4(b)(1)(B). For purposes of Health and Safety Code section 1375.4(b)(1)(B), a sponsoring organization shall have a TNE of at least twice the

total of all amounts that it has guaranteed to all persons and entities, or instuations where the organization can demonstrate to the Director's satisfaction that a lesser amount is sufficient a TNE in an amount approved by the Director. If an organization has a sponsoring organization, the organization shall provide information to the external party demonstrating the capacity of the sponsoring organization to guarantee the organization's debts, as well as the nature and scope of the guarantee provided, consistent with Health and Safety Code section 1375.4(b)(1)(B).

(E) A statement as to whether or not the organization has, at all times during the quarter, maintained a cash-to-claims ratio as required in section (a), calculated in a manner consistent with GAAP. If the required cash-to-claims ratio has not been maintained at all times, a statement shall be included in the quarterly financial survey report that describes in detail the following with respect to the deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

(2) For organizations serving less than 10,000 covered lives under all risk arrangements as of December 31 of the preceding calendar year:

(A) The disclosure statement set forth in sections (b)(1)(B), (C), (D) and (E) above.

(B) In the event an organization serving less than 10,000 covered lives under all risk arrangements: (i) fails to satisfactorily demonstrate its compliance with the reviewing or grading criteria; (ii) experiences an event that materially alters the organization's ability to remain compliant with the reviewing or grading criteria; (iii) is found, by the external party's review or audit activities, to potentially lack sufficient financial capacity to continue to accept financial risk for the delivery of health care services consistent with the requirements of section 1300.70(b)(2)(H)(1); or (iv) is found, through the Department's HMO Help Center, medical audits and surveys, or any other source, to be potentially delaying referrals, authorizations, or access to basic health care services based on financial considerations, the organization shall, within 30 calendar days of the Department's written request, begin submitting complete quarterly financial survey reports pursuant to section 1300.75.4.2(b)(1).

(c) Annual Financial Survey. (1) Regardless of the number of covered lives served under all risk arrangements, organizations shall submit to the external party, not more than one hundred fifty (150) days after the close of the organization's fiscal year beginning on or after January 1, 2004, and not more than one hundred fifty (150) days after the close of each of the organization's subsequent fiscal years, an annual financial survey report in an electronic format to be supplied by the Department pursuant to section 1300.41.8 of title 28 California Code of Regulations, based upon the organization's annual audited financial statement prepared by an independent certified public accountant in accordance with generally accepted auditing standards, and containing all of the following:

(2) Annual financial survey report, based upon the organization's annual audited financial statements (including at least a balance sheet, an income statement, a statement of cash

flows, and footnote disclosures), or in the case of a nonprofit entity, comparable financial statements , and supporting schedule information, (including but not limited to aging of receivable information and debt maturity information), for the immediately preceding fiscal year, prepared by the independent certified public accountant in accordance with GAAP.

(3) Financial survey reports of an organization required pursuant to these Solvency Regulations shall be on a combining basis with an affiliate if the organization or the affiliate is legally or contractually dependent upon the other for the payment of claims for health care services to enrollees. Any affiliated entity included in the report shall be separately identified. For the purposes of this section, an organization's use of a "sponsoring organization" arrangement to reduce its liabilities for the purposes of calculating TNE and working capital shall not be construed to automatically create a legal or contractual obligation to pay claims for health care services for enrollees.

(A) When combined financial statements are required by this regulation, the independent accountant's report or opinion must address all the entities included in the combined financial statements. If the accountant's report or opinion makes reference to the fact that another auditor performed a part of the examination, the organization shall also file the report or opinion issued by the other auditor.

(B) For purposes of determining the independence of the certified public accountant, the regulations of the California State Board of Accountancy (division 1, sections 1 through 99.2, title 16, California Code of Regulations), shall apply.

(4) The opinion of the independent certified public accountant indicating whether the organization's annual audited financial statements present fairly, in all material respects, the financial position of the organization, and whether the financial statements were prepared in accordance with GAAP. If the opinion is qualified in any way, the survey report shall include an explanation regarding the nature of the qualification.

(5) A statement as to whether or not the organization has estimated and documented, on a monthly basis, its liability for IBNR claims, pursuant to a method specified in section 1300.77.2, and that these estimates are the basis for the financial survey reports submitted under these Solvency Regulations. If the estimated and documented liability has not met the requirements of section 1300.77.2, a statement shall be included in the annual financial survey report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, the action taken to correct the deficiency, and the results of that action. An organization failing to estimate and document, on a monthly basis, its liability for IBNR claims, or maintaining its books and records on a cash accounting basis, shall be deemed to have failed to maintain, at all times, positive TNE and positive working capital as set forth in subsection (3) below.

(6)(A) A statement as to whether or not the organization has, at all times during the year, maintained positive TNE, as defined in section 1300.76(e); and has, at all times during the year, maintained positive working capital, calculated in a manner consistent with

GAAP. If either the required TNE or the required working capital has not been maintained at all times, a statement shall be included in the annual financial survey report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

(B) The organization may reduce its liabilities for purposes of calculating its TNE and working capital in a manner allowed by Health and Safety Code section 1375.4(b)(1)(B), so long as the sponsoring organization has filed, with the Department: (1) its audited annual financial statements within 120 days of the end of the sponsoring organization's fiscal year and (2) a copy of the written guarantee meeting the requirements of Health and Safety Code section 1375.4(b)(1)(B). For purposes of Health and Safety Code section 1375.4(b)(1)(B), a sponsoring organization shall have a TNE of at least twice the total of all amounts that it has guaranteed to all persons and entities, or a TNE in an amount approved by the Director, in situations where the organization can demonstrate to the Director's satisfaction that a lesser amount is sufficient. If an organization has a sponsoring organization, the organization shall provide information demonstrating the capacity of the sponsoring organization to guarantee the organization's debts as well as the nature and scope of the guarantee provided consistent with Health and Safety Code section 1375.4(b)(1)(B).

(7) A statement as to whether or not the organization has at all times during the year maintained a cash-to-claims ratio as required in section (a) , calculated in a manner consistent with GAAP. If the required cash-to-claims ratio has not been maintained at all times, a statement shall be included in the quarterly financial survey report that describes in detail the following with respect to the deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

(6) A statement as to whether the organization maintains reinsurance and/or professional stop-loss coverage.

(d) Statement of Organization Survey. Submit to the Department or its designated agent, a "Statement of Organization," in an electronic format to be filed along with the annual financial survey report, which shall include the following information, as of December 31 of each calendar year prior to the filing:

(1) Name and address of the organization;

(2) A financial and public contact person, with title, address, telephone number, fax number, and e-mail address;

(3) A list of all health plans with which the organization maintains risk arrangements;

(4) Whether the organization is an Independent Practice Association (IPA), Medical Group, Foundation, other entity, or some combination thereof. If the organization is a

foundation, identify each and every medical group within the foundation, and whether any of those medical groups independently qualifies as a risk-bearing organization as defined in Health and Safety Code section 1375.4(g);

(5) Whether the organization is a professional corporation, partnership, not-for-profit corporation, sole proprietor, or other form of business. If the organization is not-for-profit, indicate whether any of its board members are officers of a hospital or hospital system;

(6) The name, address and principal officer of each of the organization's affiliates as defined in title 28, California Code of Regulations, section 1300.45(c)(1) and (2);

(7) Whether the organization is partially or wholly owned by a hospital or hospital system;

(8) A matrix listing all major categories of medical care offered by the organization, including but not limited to, anesthesiology, cardiology, orthopedics, ophthalmology, oncology, obstetrics/gynecology and radiology. Next to each listed category in the matrix, a disclosure of the compensation model (salary, fee-for-service, capitation, other) used by the organization to compensate the majority of providers of that category of care;

(9) An approximation of the number of enrollees served by the organization under a risk arrangement, pursuant to a list of ranges developed by the Department;

(10) Any Management Services Organization (MSO) that the organization contracts with for administrative services;

(11) The total number of contracted physicians in employment and/or contractual arrangements with the organization;

(12) Disclosure of the organization's primary service area (excluding out-of-area tertiary facilities and providers) by California county or counties;

(13) The identification of the organization's address, telephone number and website link where providers may access written information and instructions for filing of provider disputes with the organization's Dispute Resolution Mechanism consistent with requirements of section 1300.71.38 of title 28, California Code of Regulations; and,

(14) Any other information that the Director deems reasonable and necessary to understand the operational structure and finances of the organization.

(e) Submit a written verification for each report made under subsections (b), (c), and (d) of this section stating that the report is true and correct to the best knowledge and belief of a principal officer of the organization, and signed by a principal officer, as defined by section 1300.45(o) of title 28, California Code of Regulations.

(f) Notify the Department and the external party no later than five (5) business days after discovering that the organization has experienced any event that materially alters its financial situation or threatens its solvency.

(g) Permit the Department and the external party to make any examination that it deems reasonable and necessary to implement Health and Safety Code section 1375.4, and provide to the external party, upon request, any books or records that the Department or the external party deems relevant to implementing this section for inspection and copying.

Authority: Sections 1344 and 1375.4, Health and Safety Code.
Reference: Section 1375.4, Health and Safety Code.

§ 1300.75.4.4. Confidentiality

(a) Financial and other records produced, disclosed or otherwise made available pursuant to Health and Safety Code section 1375.4, and to these Solvency Regulations shall be received and maintained on a confidential basis and protected from public disclosure, unless as otherwise determined by the Director, except that:

(1) Within 120 days following each reporting period due date, the Department of Managed Health Care (Department) will make the following information available for public inspection:

(A) A list of all provider organizations currently identified as risk-bearing organizations;

(B) A list of all risk-bearing organizations that have submitted substantially complete financial survey forms, if required, and whether the risk-bearing organization's submission reflects that the organization has met each of the Grading Criteria;

(C) A "non- compliant" list of all organizations that that fail to substantially comply with the reporting obligations, including the submission of the financial survey reports specified in Section 1300.75.4.2 title 28, California Code of Regulations;

(D) All information contained in the Statement of Organization of a risk-bearing organization; and

(E) A compliance report reflecting whether each organization's compliance with the grading criteria that shall utilize:

1. The designation of "met" to be assigned for each grading criteria met by the organization;

2. The designation of "not met" to be assigned for each grading criteria not met by the organization;

3. The relative working capital of each organization, consistent with section 1300.75.4.2(a)(4), presented as a ratio of current assets divided by current liabilities;

4. The relative tangible net equity (TNE) of each organization, consistent with the section 1300.75.4.2(a)(4), presented as a ratio of tangible net assets divided by total liabilities;

5. Claims payment timeliness in a percentage format, consistent with the section 1300.75.4.2(a)(2), reflecting the amount of claims that the organization is paying on a timely basis;

6. To the extent feasible, each financial item described in paragraphs 1 through 6 shall be presented for both the current and the four previous reporting periods.

(F) Comparative, aggregated data on all organizations, and information that enables consumers to assess an organization's relative financial viability consistent with section 1300.75.4.4 title 28, California Code of Regulations.

(b) Information received and maintained on a confidential basis pursuant to this section may be disclosed by the Director, at the Director's sole discretion, under the following circumstances:

(1) To other local, state or federal regulatory or law-enforcement agencies in accordance with the law;

(2) When necessary or appropriate in any proceeding or investigation conducted by the Department or the external party;

(3) To explain the Department's decision to approve or disapprove an organization's request for approval of a Corrective Action Plan (CAP) submitted in accordance with section 1300.75.4.8.title 28, California Code of Regulations ; and,

(4) Upon a determination by the Director that the justification for the confidential treatment no longer exists.

AUTHORITY:
Note: Authority cited: Sections 1344 and 1375.4, Health and Safety Code.
Reference: Section 1375.4, Health and Safety Code.

1300.75.4.7. Organization Evaluation.

(a) Every contract involving a risk arrangement between a plan and an organization shall require the organization to comply with the Department of Managed Health Care's and the external party's review and audit process and determination of the organization's satisfaction of the Grading Criteria. The contract shall also require the organization, as part of this process, to do all of the following:

(1) Permit the Department of Managed Health Care (Department) and the external party to perform any of the following activities:

(A) Obtain and evaluate supplemental financial information pertaining to the organization when: (i) the organization fails to satisfactorily demonstrate its compliance with the Grading Criteria; (ii) the organization experiences an event that materially alters its ability to remain compliant with the Grading Criteria; (iii) the Department's or external party's review or audit process indicates that the organization may have insufficient financial capacity to continue to accept financial risk for the delivery of health care services consistent with the requirements of sections 1300.70(b)(2)(H)(1); or, (iv) title 28, California Code of Regulations, the Department receives information from complaints submitted to the HMO Help Center, health plan reporting, medical audits and surveys or any other source that indicates the organization may be delaying referrals or authorizations or failing to meet access standards for basic health care services based on financial considerations.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

1300.75.4.8. Corrective Action.

Every contract involving a risk arrangement between a plan and an organization shall require the plan and the organization to comply with a process administered by the Department of Managed Health Care (Department) and the external party for the development and implementation of Corrective Action Plans (CAPs).

(a) Beginning with the financial survey submission filed for the first quarter of calendar year 2005, organizations reporting deficiencies in any of the Grading Criteria shall simultaneously submit a self-initiated CAP, in an electronic format developed by the Department, to the Department, the external party, and every plan with which the organization maintains a contract involving a risk arrangement that meets the requirements of paragraphs 1 through 6 of subdivision (d) of this section. To the extent possible, the self-initiated CAP shall be set forth in a single document that addresses the concerns of all plans with which the organization maintains a contract that includes a risk arrangement.

Unless, within 30 days of the receipt of an organization's self-initiated CAP, a contracting health plan provides written notice to the external party and the risk-bearing organization stating the reason for its objections, or the external party provides written notification to the organization and its contracting health plans stating its objections, the self-initiated CAP shall be considered a final CAP.

(1) Timetables specified in the self-initiated CAP for correcting working capital deficiencies existing on or before December 31, 2004, shall not exceed 12 months. Timetables specified in the self-initiated standardized CAP for correcting working capital deficiencies occurring after December 31, 2005, shall not exceed six (6) months.

(2) Timetables specified in the self-initiated CAP for correcting tangible net equity (TNE) deficiencies existing on or before December 31, 2004, shall not exceed 18 months. Timetables specified in the self-initiated standardized CAP for correcting TNE deficiencies occurring after December 31, 2004, shall not exceed 12 months.

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

(4) Timetables specified in the self-initiated CAP for correcting claims timeliness deficiencies shall not exceed six (6) months.

(5) Timetables specified in the self-initiated CAP for correcting cash-to-claims ratio deficiencies shall not exceed six (6) months.

(b) An organization with deficiencies in any of the Grading Criteria that are not subject to a self-initiated CAP, as outlined in subsection (a) above, shall develop a CAP proposal that meets the requirements of subsection (d) of this section and is developed in accordance with the process required by subsection (e) of this section.

(c) Notwithstanding subsections (a) and (b) above, the Department or external party may initiate a process for a customized CAP whenever the Department or external party determines: (1) that an organization is non-compliant with its self-initiated CAP for more than 90 days; (2) an organization has experienced an event that materially alters the organization's ability to remain compliant with the Grading Criteria; or, (3) the Department's or external party's review process indicates that the organization may lack sufficient financial capacity to meet its contractual obligations consistent with the requirements of section 1300.70(b)(2)(H)(1) title 28 California Code of Regulations.

(d) All CAPs must:

(1) Identify the Grading Criteria that the organization has failed to meet;

(2) Identify any deficiency revealed pursuant to subsections (a) or (c) of this section and the nature and cause of that deficiency;

(3) Identify the amount by which the organization has failed to meet the Grading Criteria;

(4) Identify all plans with which the organization has contracts involving a risk arrangement, including the identification of the name, title, telephone and facsimile numbers, and postal and e-mail addresses for the person responsible at each contracting health plan for monitoring compliance with the final CAP;

(5) Describe the specific actions the organization has taken or will take to correct any deficiency identified in subsections(1) and (2) of this section. This description should include any written representations made by contracting health plans to assist the

organization in the implementation of its CAP. The actions shall be appropriate and reasonable in scope and breadth depending upon the nature and degree of the deficiency, and acceptable to the external party;

(6) Describe the timeframe to complete the corrective action to remedy the deficiency, and a schedule for submitting progress reports to the external party and the organization's contracting health plans;

(7) Identify the name, title, telephone and facsimile numbers, and postal and e-mail addresses for the person responsible at the organization for ensuring compliance with the final CAP; and,

(8) If requested by the Department or the external party, describe: (A) the organization's patient record retention and storage policies, (B) the procedures and the steps the organization will take to ensure that patient medical records are appropriately stored and maintained; and, (C) the procedures and the steps the organization will take to ensure that patient medical records will be readily available and transferable to patients in the event the organization ceases operations or the organization fails to meet its obligations set forth in the final CAP. At a minimum, an organization's patient medical records policies and procedures shall be consistent with existing laws relating to the responsibilities for the preservation and maintenance of medical records and the protection of the confidentiality of medical information.

(e) In the event that a contracting health plan files a written objection with the external party and the risk-bearing organization, or the Department or external party provides the organization and its contracting health plans its objection within 30 days of receipt of the organization's self-initiated CAP, the organization shall proceed to develop a customized CAP proposal as follows:

(1) Within 30 calendar days of receipt of a written objection to a self-initiated CAP, the organization shall submit a CAP, as described in subsection (d) of this section, in an electronic format developed by the Department, to every plan with which the organization has a contract involving a risk arrangement. To the extent possible, the CAP shall be prepared as a single document that addresses the concerns of all plans with which the organization maintains a contract that includes a risk arrangement.

(2) Each contracting health plan shall have the opportunity to submit comments and recommended revisions to the CAP. The contracting health plan must submit its comments or recommended revisions to the organization and the external party in an electronic format within fifteen (15) days of receipt of the CAP.

(3) Within fifteen (15) days of receipt of the contracting health plans' comments and recommended revisions to the CAP, the organization shall review and consider the comments and recommendations and, if necessary, meet with the plans to discuss differences.

(4) Within sixty (60) days of receipt of a contracting plan's, external party's or the Department's written objection to the CAP, the organization shall submit a revised CAP in an electronic format developed by the Department, to the external party and to every plan with which the organization has a contract involving a risk arrangement. The revised CAP shall specify which of the organization's contracting plans have indicated agreement with the revised CAP. Within seven (7) days of a request by the external party, the organization shall submit electronically a copy of all prior comments and recommendations received from the plans with which the organization has a contract that includes a risk arrangement.

(5) Within ten (10) days of receipt of the revised CAP, any plan not in agreement may submit electronically comments and proposed alternatives to the external party. Any plan submitting comments or alternatives to the external party shall also provide a copy to the organization.

(6) Within seven (7) days of receipt of any non-concurring plan comments, the organization may submit responsive comments to the external party. The organization shall also provide a copy of any response to a plan's comment to that particular plan.

(7) If not all plans agree with the revised CAP, the external party may hold meetings with the organization and the plans to attempt to reconcile the differences.

(8) The external party shall prepare its recommendation to the Department whether to approve, approve as amended, disapprove unless modified, or disapprove the revised CAP within forty (45) days after receiving it from the organization. If the Department approves or approves, with amendment, the revised CAP, it shall be designated a final CAP. If the Department does not act upon the recommendations of the external party within 30 days, the external party's recommendation shall be deemed approved. If the Department modifies the external party's recommendation or disapproves the external party's recommendation, the Department shall so notify the external party, the organization, and the organization's contracting health plans, and provide the reasons for the disapproval.

(9) Within ten (10) days of receipt of written notice that the Department disapproves unless modified, or disapproves the recommendation of the external party, the organization shall revised its CAP proposal and resubmit it to the external party and to every plan with which the organization maintains a contract involving a risk arrangement. Within seven (7) days of receipt, contracting plans may submit comments and alternatives to the external party, and to the organization regarding the revisions to CAP. Within seven (7) days of receipt of comments from the nonconcurring plan(s), the organization may submit responsive comments to the external party. The organization shall provide a copy of its response to a plan's comment to that particular plan. The external party shall prepare its recommendation to the Department whether to approve, or approve the revised CAP, within forty-five (45) days after receipt. If the Department approves, or approves as modified resubmitted revised CAP it shall become the final CAP. If the Department does not act upon the external party's recommendations relating

to the resubmitted CAP within forty-five (45) days of receipt, it shall be deemed approved, and shall become the final CAP. A copy of the final CAP consistent with section 1300.75.4.4 (f), shall be provided to every health plan with which the organization maintains a contract involving a risk arrangement, within seven (7) days of approval or the deeming of approval.

(10) A final CAP shall remain in effect until the organization demonstrates compliance with the requirements of the CAP, or the CAP expires in accordance with its own terms.

(f) CAP Reporting:

(1) Each periodic progress report prepared pursuant to a final CAP shall be submitted to the external party and all plans with which the organization has a contract involving a risk arrangement, and shall include a written verification stating that the periodic progress report is true and correct to the best knowledge and belief of a principal officer of the organization, as defined by section 1300.45(o) title 28 California Code of Regulations.

(2) In addition to the quarterly progress reports specified in a CAP, every contract involving a risk arrangement between a plan and an organization shall require that:

(A) the organization advise the plan, the external party, and the Department in writing within thirty (30) days if the organization experiences an event that materially alters the organization's ability to remain compliant with the requirements of a final CAP; and

(B) the organization, upon the Department's or the external party's request, provide additional documentation to the Department, external party, and its contracting plans to demonstrate the organization's progress towards fulfilling the requirements of a CAP.

AUTHORITY:
Note: Authority cited: Sections 1344 and 1375.4, Health and Safety Code.
Reference: Section 1375.4, Health and Safety Code.

1300.75.4.5. Plan Compliance

~~Any failure of a plan to comply with the requirements of Health and Safety Code Section 1375.4 and these solvency regulations shall constitute grounds for disciplinary action against the plan. The Director may seek and employ any combination of remedies and enforcement procedures provided under the Act, to enforce Health and Safety Code Section 1375.4 and these solvency regulations.~~

(a) Every plan that maintains a risk arrangement with an organization shall have adequate procedures in place to ensure:

(1) That plan personnel review all reports and financial information made available pursuant to Health and Safety Code section 1375.4 and these Solvency Regulations as part of the plan's responsibility to evaluate and ensure the financial viability of its

arrangements consistent with section 1300.70(b)(2)(H)(1) title 28, California Code of Regulations;

(2) That the plan shall not assign or add any additional enrollees to the risk arrangement with an organization without the prior approval of the Director, when the Department of Managed Health Care (Department) or the external party notifies the plan and the organization that any one of the following has occurred:

(A) The organization has failed to substantially comply with the reporting obligations specified in section 1300.75.4.2 Title 28, California Code of Regulations, by failing to file a required periodic financial and organizational information disclosure, including the filing of an annual financial survey report based upon an audited financial statement prepared in accordance with generally accepted accounting principles (GAAP), or by failing to include significant portions of information on a required periodic financial organizational information disclosure;

(B) The organization has refused to permit the activities of the Department or the external party as specified in Health and Safety Code section 1375.4 or in these Solvency Regulations; or,

(C) The organization has failed to substantially comply with the requirements of a final CAP for a period of more than 90 days, as determined by the external party

(D) The prohibition on assignments of additional enrollees to an organization pursuant to subsections (A), (B) and (C) of this section shall not apply to dependents of enrollees who are already under the risk-arrangement with the organization or to enrollees who selected the organization during an open enrollment or other selection period that was prior to the effective date of the prohibition on the assignment of additional enrollees.

(E) The prohibition on the assignment of additional enrollees shall take effect thirty (30) days after the date of Department's or the external party's notification to the organization's contracting plan(s), and shall remain in effect until the external party notifies the Department and the organization's contracting health plan in writing that the organization's non-compliance has been remedied.

(3) That the plan complies with the corrective action process and cooperates in the implementation of a final CAP, including but not limited to, implementing contingency plans for continuous delivery of health care services to plan enrollees served by the organization.

(4) That the plan shall advise the Department, the external party, and the organization in writing within thirty (30) days of becoming aware: (i) that a contracting organization is not in compliance with the requirements of a final CAP, or (ii) that an organization's conduct may cause the plan to be subject to disciplinary action pursuant to Health and Safety Code section1386.

(5) That if a plan proposes to transfer plan enrollees receiving care from an organization to alternative providers while the organization remains compliant with a final CAP and the reassignment is based, in part, on the organization's failure to meet one or more of the Grading Criteria, the plan shall, prior to transferring enrollees from that organization, file with the Department a specific Provider Transition Plan pursuant to section 1375.65. The Director may disapprove, postpone or suspend the plan's proposed transfer of enrollees if the plan fails to adequately demonstrate any of the following:

(A) That the proposed reassignment of enrollees will not cause the organization's failure or result in the organization ceasing operations within three (3) months;

(B) That the reassignment of enrollees will not result in the unavailability of physician services or in-network hospital panels for enrollees of any plan served by the organization;

(C) That the organization lacks the financial and administrative capacity to provide timely access to care through an adequate network of qualified health care providers;

(D) That the failure to transfer enrollees to new providers will likely result in either denials or delays in basic health care services or continuity of care for the plan's enrollees;

(E) That the organizations or providers to which the enrollees will be transferred under a risk arrangement have sufficient administrative and financial capacity to meet their contractual obligations for the reassigned enrollees under the risk arrangement; or

(F) That the proposed Provider Transition Plan provides for timely access to care from qualified health care providers for the transferred enrollees, as required by section 1367.

(6) Notwithstanding subsection (5) of this section, nothing in these regulations shall limit or impair the Director's authority, consistent with Health and Safety Code sections 1367, 1373.65 (b) and 1391.5, to require a plan to reassign or transfer plan enrollees to alternate providers or organizations on an expedited basis to avoid imminent harm to enrollees.
(c) Every contract involving a risk arrangement between a plan and an organization shall provide that an organization's failure to substantially comply with the contractual requirements required by these solvency regulations shall constitute a material breach of the risk arrangement contract. A plan shall not request or accept a waiver of any the contractual requirements set forth in these Solvency Regulations.

(d) Within 30 days of notification pursuant to section 1300.75.4.5(a)(2)(C) title 28, California Code of Regulations, a plan shall submit to the Department a specific Provider Transition Plan for the deficient organization which provides for the continuity of care for plan enrollees served by the organization.

(e) Any failure of a plan to comply with the requirements of Health and Safety Code section 1375.4 and these solvency regulations shall constitute grounds for disciplinary action against the plan pursuant to Health and Safety Code section1386.

(f) The Director may seek and employ any combination of remedies and enforcement procedures provided under the Knox-Keene Act, to enforce Health and Safety Code section 1375.4 and these solvency regulations.

AUTHORITY:

Note: Authority cited: Sections 1344 and 1375.4, Health and Safety Code.
Reference: Section 1375.4, Health and Safety Code.