1300.75.4.1 Risk Arrangement Disclosure

(a)

Every contract involving a risk arrangement between a plan and an organization or between a sub-delegating organization and an organization shall require the plan or the sub-delegating organization to do all of the following: (1) Disclose through electronic transmission (or in writing, if agreeable to both the organization and the plan or the sub-delegating organization) to the organization, on a monthly basis within fifteen (15) calendar days of the beginning of each report month, the following information for each enrollee assigned to the organization: member identification number, name, birth date, gender, address (including zip code), plan contract selected, employer group identification, the identity of any other third party coverage, if known to the health plan, enrollment/disenrollment dates, medical group/IPA number, provider effective date, type of change to coverage, co-payment, deductible, the amount of capitation to be paid per enrollee per month, and the primary care physician when the selection of a primary care physician is required by the plan. (2) Disclose through electronic transmission (or in writing, if agreeable to both the organization and the plan or the sub-delegating organization) to the organization, on a monthly basis within fifteen (15) calendar days of the beginning of each report month, the names, member identification numbers, and total numbers of enrollees added or terminated under each benefit plan or sub-delegating organization contract served by the organization. (3) If the

information provided in paragraphs (1) and (2) is provided in more than one report, the plan or sub-delegating organization shall disclose through electronic transmission (or in writing, if agreeable to both the organization and the plan or the sub-delegating organization) to the organization, on a quarterly basis, within forty-five (45) calendar days of the close of each quarter, a reconciliation of the variances between the information provided in paragraphs (1) and (2) above. If the information in paragraphs (1) and (2) is provided in more than one report, all reports shall be processed as of the same date. (4) On the contract anniversary date, disclose to the organization, for the purpose of assisting the organization to be informed regarding the financial risk assumed under the contract, the following information for each and every type of risk arrangement (including, but not limited to, Medicare Advantage, Medi-Cal, and commercial, including large group, small group, and individual) under the contract, including: (A) a matrix of responsibility for medical expenses (physician, institutional, ancillary, and pharmacy) which will be allocated to the organization, facility, the plan or the sub-delegating organization under the risk arrangement; (B) expected/projected utilization rates and unit costs for each major expense service group (inpatient, outpatient, primary care physician, specialist, pharmacy, home health, durable medical equipment (DME), ambulance and other), the source of the data and the actuarial methods employed in determining the utilization rates and unit costs by benefit plan type for the type of risk arrangement; and (C) all factors used to adjust payments or risk-sharing targets, including but not limited to the following: age, sex, localized geographic area, family size, experience rated, and benefit plan design, including copayment/deductible levels. (5) Disclose through electronic transmission (or in writing, if agreeable to both the organization and the plan or the sub-delegating organization) to the organization, on a quarterly basis, within forty-five (45)

calendar days of the close of each quarter, a detailed description of each and every amount (including expenses and income) that is sufficient to allow verification of the amounts allocated to the organization and to the plan or the sub-delegating organization under each and every risk-sharing arrangement. Where applicable, the following information, at a minimum, shall be provided: (A) The total number of member months; (B) The total budget allocation for the member months; (C) The total expenses paid during the period; (D) A description of the incurred but not reported (IBNR) claims methodology used for incurred expenses during the period; and (E) A description of each and every amount of expense allocated to the risk arrangement by member identification number, date of service, description of service by claim codes, net payment and date of payment. (6) For all risk-sharing arrangements, provide the organization with a preliminary payment report consistent with the requirements of paragraph (5) no later than one-hundred and fifty (150) days and payment no later than one-hundred and eighty (180) days after the close of the organization's contract year, or the contract termination date, whichever occurs first.

(1)

Disclose through electronic transmission (or in writing, if agreeable to both the organization and the plan or the sub-delegating organization) to the organization, on a monthly basis within fifteen (15) calendar days of the beginning of each report month, the following information for each enrollee assigned to the organization: member identification number, name, birth date, gender, address (including zip code), plan contract selected, employer group identification, the identity of any other third party coverage, if known to the health plan, enrollment/disenrollment dates, medical group/IPA number, provider effective date, type of change to coverage, co-payment, deductible, the amount of capitation to be paid per enrollee per month, and the primary

care physician when the selection of a primary care physician is required by the plan.

(2)

Disclose through electronic transmission (or in writing, if agreeable to both the organization and the plan or the sub-delegating organization) to the organization, on a monthly basis within fifteen (15) calendar days of the beginning of each report month, the names, member identification numbers, and total numbers of enrollees added or terminated under each benefit plan or sub-delegating organization contract served by the organization.

(3)

If the information provided in paragraphs (1) and (2) is provided in more than one report, the plan or sub-delegating organization shall disclose through electronic transmission (or in writing, if agreeable to both the organization and the plan or the sub-delegating organization) to the organization, on a quarterly basis, within forty-five (45) calendar days of the close of each quarter, a reconciliation of the variances between the information provided in paragraphs (1) and (2) above. If the information in paragraphs (1) and (2) is provided in more than one report, all reports shall be processed as of the same date.

(4)

On the contract anniversary date, disclose to the organization, for the purpose of assisting the organization to be informed regarding the financial risk assumed under the contract, the following information for each and every type of risk arrangement (including, but not limited to, Medicare Advantage, Medi-Cal, and commercial, including large group, small group, and individual) under the contract, including: (A) a matrix of responsibility for medical expenses (physician, institutional, ancillary, and pharmacy) which will be allocated to the organization, facility, the plan or the sub-delegating organization under the risk arrangement; (B) expected/projected utilization rates and

unit costs for each major expense service group (inpatient, outpatient, primary care physician, specialist, pharmacy, home health, durable medical equipment (DME), ambulance and other), the source of the data and the actuarial methods employed in determining the utilization rates and unit costs by benefit plan type for the type of risk arrangement; and (C) all factors used to adjust payments or risk-sharing targets, including but not limited to the following: age, sex, localized geographic area, family size, experience rated, and benefit plan design, including copayment/deductible levels.

(A)

a matrix of responsibility for medical expenses (physician, institutional, ancillary, and pharmacy) which will be allocated to the organization, facility, the plan or the sub-delegating organization under the risk arrangement;

(B)

expected/projected utilization rates and unit costs for each major expense service group (inpatient, outpatient, primary care physician, specialist, pharmacy, home health, durable medical equipment (DME), ambulance and other), the source of the data and the actuarial methods employed in determining the utilization rates and unit costs by benefit plan type for the type of risk arrangement; and

(C)

all factors used to adjust payments or risk-sharing targets, including but not limited to the following: age, sex, localized geographic area, family size, experience rated, and benefit plan design, including copayment/deductible levels.

(5)

Disclose through electronic transmission (or in writing, if agreeable to both the organization and the plan or the sub-delegating organization) to the organization, on a quarterly basis, within forty-five (45) calendar days of the close of each quarter, a detailed description of each and every amount (including expenses and income) that is

sufficient to allow verification of the amounts allocated to the organization and to the plan or the sub-delegating organization under each and every risk-sharing arrangement. Where applicable, the following information, at a minimum, shall be provided: (A) The total number of member months; (B) The total budget allocation for the member months; (C) The total expenses paid during the period; (D) A description of the incurred but not reported (IBNR) claims methodology used for incurred expenses during the period; and (E) A description of each and every amount of expense allocated to the risk arrangement by member identification number, date of service, description of service by claim codes, net payment and date of payment.

(A)

The total number of member months;

(B)

The total budget allocation for the member months;

(C)

The total expenses paid during the period;

(D)

A description of the incurred but not reported (IBNR) claims methodology used for incurred expenses during the period; and

(E)

A description of each and every amount of expense allocated to the risk arrangement by member identification number, date of service, description of service by claim codes, net payment and date of payment.

(6)

For all risk-sharing arrangements, provide the organization with a preliminary payment report consistent with the requirements of paragraph (5) no later than one-hundred and fifty (150) days and payment no later than one-hundred and eighty (180) days after the

close of the organization's contract year, or the contract termination date, whichever occurs first.

(b)

In addition to the disclosures required by subsection (a) of this regulation, every contract involving a risk-sharing arrangement between a plan and an organization and, between a sub-delegating organization and an organization, shall require the plan or sub-delegating organization to disclose annually on the contract anniversary date, the amount of payment for each and every service to be provided under the contract, including any fee schedules or other factors or units used in determining the fees for each and every service. To the extent that reimbursement is made pursuant to a specified fee schedule, the contract shall incorporate that fee schedule by reference, and further specify the Medicare RBRVS year if RBRVS is the methodology or if another model or methodology is used for fee schedule development. For any proprietary fee schedule, the contract shall include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.

(c)

In addition to the disclosures required by subsection (a) of this regulation, every contract involving a risk-shifting arrangement between a plan and an organization or, between a sub-delegating organization and an organization, shall require the plan or the sub-delegating organization to disclose annually on the contract anniversary date, in the case of capitated payment, the amount to be paid per enrollee per month, or the respective amount under a percentage of premium arrangement. For any deductions that the plan or sub-delegating organization may take from any capitation payment, the plan or sub-delegating organization shall provide details sufficient to allow the organization to verify the accuracy and

appropriateness of the provided deduction.