§ 1300.71.31. Methodology for Determining Average Contracted Rate; Default Reimbursement Rate.

(a) The following definitions apply for the purpose of this section:

(1) "Average contracted rate" and ACR mean the claims-volume weighted average of the contracted commercial rates paid by the payor for the same or similar services in the geographic region, in the applicable calendar year, for services most frequently subject to section 1371.9 of the Knox-Keene Act. The applicable calendar year is two years prior to the year in which the health care service was rendered. Beginning January 1, 2024, this rate is then adjusted to the date the service was rendered by using the inflation adjustment described in subdivision (a)(2)(B) of section 1371.31 of the Knox-Keene Act.

(2) "Default reimbursement rate" means the greater of the average contracted rate or 125 percent of the Medicare rate, payable to a noncontracting individual health professional pursuant to section 1371.31 of the Knox-Keene Act.

(3) "Geographic region" has the meaning described in subdivision (a)(6) of section 1371.31 of the Knox-Keene Act, whether the default reimbursement rate is based on the Medicare rate or the average contracted rate.

(4) "Medicare rate" means the amount Medicare reimburses on a fee-for service basis for the same or similar health care services in the geographic region in which the health care services were rendered, for the calendar year in which the health care service was rendered, on a "par" basis. "Par" basis means the reimbursement rate paid to health care service providers participating in the Medicare program by accepting Medicare assignment.

(5) "Payor" means a health plan or its delegated entity that has the responsibility for payment of a claim for health care services subject to section 1371.9 of the Knox-Keene Act. The term Payor excludes health plans and entities described in subdivision (e) of section 1371.31 of the Knox-Keene Act.

(6) "Services most frequently subject to section 1371.9" of the Knox-Keene Act means the health care services that, when added together, comprise at least 80 percent of the payor's statewide claims volume for health care services subject

to section 1371.9 in the applicable calendar year, as defined in subdivision (a)(1) of this section.

(7) "Services subject to section 1371.9" of the Knox-Keene Act are nonemergency health care services provided to an enrollee by a noncontracting individual health professional at a contracting health facility where the enrollee received covered health care services, or nonemergency health care services provided to the enrollee by a noncontracting individual health professional as a result of covered health care services received at a contracting health facility.

(8) The definitions in subdivision (f) of section 1371.9 of the Knox-Keene Act apply for the purpose of this section.

(b) For all health care services subject to section 1371.9 of the Knox-Keene Act, payors shall comply with subdivision (e) and do the following:

(1) For health care services most frequently subject to 1371.9, payors shall use the methodology described in this section to determine the average contracted rate; or

(2) For health care services that do not fall under subdivision (b)(1), the payor may, but is not required to, use the methodology described in this section to determine the average contracted rate. If the payor uses a different methodology, that different methodology shall be a reasonable method of determining the average contracted commercial rates paid by the payor for the same or similar services in the geographic region, in the applicable calendar year.

(c) Methodology for determining the average contracted rate.

(1) Except as specified in subdivision (c)(6), for each health care service procedure code for services most frequently subject to section 1371.9 of the Knox-Keene Act, the payor shall calculate the claims volume-weighted mean rate:

Rate = sum of [the allowed amount for the health service code under each contract x number of claims paid for each allowed amount]/Total number of claims paid for that code across all commercial contracts. Beginning January 1, 2024, this rate is then adjusted to the date the service was rendered by using the inflation adjustment described in subdivision (a)(2)(B) of section 1371.31 of the Knox-Keene Act.

Example: For hypothetical health care service code Z, and for a particular combination of the factors described in subdivision (c)(3), the payor's allowed amounts under its commercial contracts are: Contract A ($10), Contract B ($15), Contract C ($12). During the applicable calendar year, the payor paid, for code Z, 25 claims under Contract A, 30 claims under contract B, and 45 claims under contract C. The rate calculation pursuant to this subdivision (c)(1) is: ($10x25)+($15x30)+($12x45) / (total claims: 100) = a base ACR rate of $12.40 for health care service code Z. Beginning January 1, 2024, the rate, so calculated, is then adjusted for inflation by the Consumer Price Index for Medical Care Services, as published by the United States Bureau of Labor Statistics, as described in subdivision (a)(2)(B) of section 1371.31 of the Knox-Keene Act.

(2) The payor shall include the highest and lowest contracted rates when calculating the rate pursuant to subdivision (c)(1) by ensuring that the "number of claims paid at that allowed amount" multiplier for each of the payor's highest and lowest contracted rates is at least 1 (one).

(3) The payor shall calculate a rate described in subdivision (c)(1) taking into account each combination of these factors, at a minimum:

(A) Health care service codes, including but not limited to Current Procedural Terminology (CPT) codes,

(B) Geographic region,

(C) Provider type and specialty,

(D) Facility type, and,

(E) Information from the independent dispute resolution process, if any, pursuant to section 1371.30 of the Knox-Keene Act.

(4) For the purpose of subdivision (c)(3)(A), the payor shall use unmodified health care service codes to calculate the average contracted rate, except that the payor shall calculate separate average contracted rates pursuant to this subdivision (c) only for CPT code modifiers "26" (professional component) and "TC" (technical component). For the purpose of this section, a modifier is a code applied to the service code that makes the service description more specific and may adjust the reimbursement rate or affect the processing or payment of the code billed.

(5) When the average contracted rate is the appropriate default reimbursement rate pursuant to subdivision (a)(1) of section 1371.31 of the Knox-Keene Act, the payor may adjust the rate determined under this subdivision (c) when it reimburses the noncontracting individual health professional, as appropriate. Appropriate reimbursement shall account for relevant payment modifiers and other health care service- or claim-specific factors in compliance with the Knox-Keene Act that affect the amount for reimbursement of health care services rendered by contracting individual health professionals.

(6) For anesthesia services subject to section 1371.9 of the Knox-Keene Act:

(A) The payor shall use the anesthesia conversion factors set forth in the payor's provider contracts instead of an "allowed amount" to complete the calculation pursuant to subdivision (c)(1).

(B) The factors that affect reimbursement pursuant to subdivision (c)(5) of this section shall include the sum of American Society of Anesthesiologists Relative Value Guide (RVG) base units, time units, and physical status modifier.

(7) The following claims shall be excluded from the average contracted rate calculation, except as specified:

(A) Case rates, bundled payments, and global rates shall be excluded, except that the payor shall include the CPT code in which a global rate is embedded per the American Medical Association CPT code description.

(B) Claims paid pursuant to capitation, risk sharing arrangements, and subcapitation, except for fee-for-service payments made by a payor who receives capitation from another entity.

(C) Denied claims.

(D) Claims not in final disposition status, meaning claims for which a final reimbursement amount pursuant to claims settlement practices required by the Knox Keene Act has not been determined by the payor, including disputed claims.

(E) Secondary payment rates pursuant to coordination of benefits clauses.

(d) Payors subject to subdivision (a)(3)(C) of section 1371.31 of the Knox-Keene Act shall use a statistically credible database reflecting rates paid to noncontracting individual health professionals for services provided in a geographic region to determine an average contracted rate required pursuant to this section and section 1371.31 of the Knox-Keene Act. This subdivision (d) applies notwithstanding any other provision of this section.

(e) Payment of default reimbursement rate.

(1) Unless otherwise agreed by the payor and the noncontracting individual health professional, and except as provided in subdivision (b) of section 1371.31 of the Knox-Keene Act, the payor shall reimburse the noncontracting individual health professional, for all services subject to section 1371.9 of the Knox-Keene Act, the default reimbursement rate.

(2) The payor shall indicate on claims payment documents the manner by which the payor satisfied this subdivision (e).

(f) Filing requirements.

(1) Payors shall electronically file with the department the policies and procedures used to determine the average contracted rates in compliance with this section by August 15, 2019, and thereafter when the policies and procedures are amended.

(2) If applicable, the payor shall demonstrate in its policies and procedures access to and use of a statistically credible database pursuant to subdivision (d) of this section including the following information:

(A) Explanation and justification of the determination that, based on the payor's model, the payor does not pay a statistically significant number or dollar amount of claims covered under section 1371.9 of the Knox-Keene Act;

(B) Information regarding which database is used for the determination of an ACR;

(C) Certification that the database is statistically credible; and

(D) Explanation and justification of the percentile or other methodology used to determine the average contracted rate, using the database.

(3) For the purpose of subdivision (f)(2), a statistically credible database shall be a nonprofit database that is unaffiliated with a payor.

(g) Enforcement. The Director shall have the civil, criminal, and administrative remedies available under the Knox-Keene Act, including section 1394.

NOTE: Authority cited: Sections 1344 and 1371.31, Health and Safety Code. Reference: Sections 1371.9 and 1371.31, Health and Safety Code.

HISTORY:

1. New section filed 9-13-2018; operative 1-1-2019 (Register 2018, No. 37).
2. Amendment of subsections (a)(1) and (c)(1) filed 10-19-2023; operative 1-1-2024 (Register 2023, No. 42).

§ 1300.71.38. Fast, Fair and Cost-Effective Dispute Resolution Mechanism.

All health care service plans and their capitated providers that pay claims (plan's capitated provider) shall establish a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes. The plan and the plan's capitated provider may maintain separate dispute resolution mechanisms for contracted and non-contracted provider disputes and separate dispute resolution mechanisms for claims and other types of billing and contract disputes, provided that each mechanism complies with sections 1367(h), 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28. Arbitration shall not be deemed a provider dispute or a provider dispute resolution mechanism for the purposes of this section.

(a) Definitions:

(1) "Contracted Provider Dispute" means a contracted provider's written notice to the plan or the plan's capitated provider challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or a bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim that contains, at a minimum, the following information: the provider's name; the provider's identification number; contact information; and:

(A) If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, the date

of service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;

(B) If the dispute is not about a claim, a clear explanation of the issue and the provider's position thereon; and

(C) If the dispute involves an enrollee or group of enrollees: the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the date of service and the provider's position thereon.

(2) "Non-Contracted Provider Dispute" means a non-contracted provider's written notice to the plan or the plan's capitated provider challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or disputing a request for reimbursement of an overpayment of a claim that contains, at a minimum, the following information: the provider's name, the provider's identification number, contact information and:

(A) If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim, a clear identification of the disputed item, including the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement of an overpayment of a claim or other action is incorrect.

(B) If the dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the date of service and the provider's position thereon.

(3) "Date of receipt" means the working day when the provider dispute or amended provider dispute, by physical or electronic means, is first delivered to the plan's or the plan's capitated provider's designated dispute resolution office or post office box. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code section 641.

(4) "Date of Determination" means the date of postmark or electronic mark on the written provider dispute determination or amended provider dispute determination that is delivered, by physical or electronic means, to the claimant's office or other address of record. To the extent that a postmark or electronic mark is unavailable to confirm the Date of Determination, the Department may consider, when auditing the plan's or the plan's capitated provider's provider dispute mechanism, the date the check is printed for any monies determined to be due and owing the provider and date the check is presented for payment. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code section 641.

(5) "Plan" for the purposes of this section means a licensed health care service plan and its contracted claims processing organization(s).

(b) Notice to Provider of Dispute Resolution Mechanism(s). Whenever the plan or the plan's capitated provider contests, adjusts or denies a claim, it shall inform the provider of the availability of the provider dispute resolution mechanism and the procedures for obtaining forms and instructions, including the mailing address, for filing a provider dispute.

(c) Submission of Provider Disputes. The plan and the plan's capitated provider shall establish written procedures for the submission, receipt, processing and resolution of contracted and non-contracted provider disputes that, at a minimum, provide that:

(1) Provider disputes be submitted utilizing the same number assigned to the original claim; thereafter the plan or the plan's capitated provider shall process and track the provider dispute in a manner that allows the plan, the

plan's capitated provider, the provider and the Department to link the provider dispute with the number assigned to the original claim.

(2) Contracted Provider Disputes be submitted in a manner consistent with procedures disclosed in sections 1300.71(*l*)(1) -(4).

(3) Non-contracted Provider Disputes be submitted in a manner consistent with the directions for obtaining forms and instructions for filing a provider dispute attached to the plan's or the plan's capitated provider's notice that the subject claim has been denied, adjusted or contested or pursuant to the directions for filing Non-contracted Provider Disputes contained on the plan's or the plan's capitated provider's website.

(4) The plan shall resolve any provider dispute submitted on behalf of an enrollee or a group of enrollees treated by the provider in the plan's consumer grievance process and not in the plan's or the plan's capitated provider's dispute resolution mechanism. The plan may verify the enrollee's authorization to proceed with the grievance prior to submitting the complaint to the plan's consumer grievance process. When a provider submits a dispute on behalf of an enrollee or a group of enrollees, the provider shall be deemed to be joining with or assisting the enrollee within the meaning of section 1368 of the Health and Safety Code.

(d) Time Period for Submission.

(1) Neither the plan nor the plan's capitated provider that pays claims, except as required by any state or federal law or regulation, shall impose a deadline for the receipt of a provider dispute for an individual claim, billing dispute or other contractual dispute that is less than 365 days of plan's or the plan's capitated provider's action or, in the case of inaction, that is less than 365 days after the Time for Contesting or Denying Claims has expired. If the dispute relates to a demonstrable and unfair payment pattern by the plan or the plan's capitated provider, neither the plan nor the plan's capitated provider shall impose a deadline for the receipt of a dispute that is less than 365 days from the plan's or the plan's capitated provider's most recent action or in the case of inaction that is less than 365 days after the most recent Time for Contesting or Denying Claims has expired.

(2) The plan or the plan's capitated provider may return any provider dispute lacking the information enumerated in either section (a)(1) or (a)(2), if the information is in the possession of the provider and is not readily accessible to the plan or the plan's capitated provider. Along with any returned provider dispute, the plan or the plan's capitated provider shall clearly identify in writing the missing information necessary to resolve the dispute consistent with sections 1300.71(a)(10) and (11) and 1300.71(d)(1), (2) and (3). Except in situation where the claim documentation has been returned to the provider, no plan or a plan's capitated provider shall request the provider to resubmit claim information or supporting documentation that the provider previously submitted to the plan or the plan's capitated provider as part of the claims adjudication process.

(3) A provider may submit an amended provider dispute within thirty (30) working days of the date of receipt of a returned provider dispute setting forth the missing information.

(e) Time Period for Acknowledgment. A plan or a plan's capitated provider shall enter into its dispute resolution mechanism system(s) each provider dispute submission (whether or not complete), and shall identify and acknowledge the receipt of each provider dispute:

(1) In the case of an electronic provider dispute, the acknowledgement shall be provided within two (2) working days of the date of receipt of the electronic provider dispute by the office designated to receive provider disputes, or

(2) In the case of a paper provider dispute, the acknowledgement shall be provided within fifteen (15) working days of the date of receipt of the paper provider dispute by the office designated to receive provider disputes.

(f) Time Period for Resolution and Written Determination. The plan or the plan's capitated provider shall resolve each provider dispute or amended provider dispute, consistent with applicable state and federal law and the provisions of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.37, 1371.4 and 1371.8 of the Health and Safety Code and section 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of title 28, and issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute or the amended provider dispute.

Copies of provider disputes and determinations, including all notes, documents and other information upon which the plan or the plan's capitated provider relied to reach its decision, and all reports and related information shall be retained for at least the period specified in section 1300.85.1 of title 28.

(g) Past Due Payments. If the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, the plan or the plan's capitated provider shall pay any outstanding monies determined to be due, and all interest and penalties required under sections 1371 and 1371.35 of the Health and Safety Code and section 1300.71 of title 28, within five (5) working days of the issuance of the Written Determination. Accrual of interest and penalties for the payment of these resolved provider disputes shall commence on the day following the expiration of "Time for Reimbursement" as forth in section 1300.71(g).

(h) Designation of Plan Officer. The plan and the plan's capitated provider shall each designate a principal officer, as defined by section 1300.45(o) of title 28, to be primarily responsible for the maintenance of their respective provider dispute resolution mechanism(s), for the review of its operations and for noting any emerging patterns of provider disputes to improve administrative capacity, plan-provider relations, claim payment procedures and patient care. The designated principal officer shall be responsible for preparing, the reports and disclosures as specified in sections 1300.71(e)(3) and (q) and 1300.71.38(k) of title 28.

(i) No Discrimination. The plan or the plan's capitated provider shall not discriminate or retaliate against a provider (including but not limited to the cancellation of the provider's contract) because the provider filed a contracted provider dispute or a non-contracted provider dispute.

(j) Dispute Resolution Costs. A provider dispute received under this section shall be received, handled and resolved by the plan and the plan's capitated provider without charge to the provider. Notwithstanding the foregoing, the plan and the plan's capitated provider shall have no obligation to reimburse a provider for any costs incurred in connection with utilizing the provider dispute resolution mechanism.

(k) Required Reports. Beginning with the 2004 calendar year and for each subsequent year, the plan shall submit to the Department no more than fifteen (15) days after the close of the calendar year, an "Annual Plan Claims Payment and Dispute Resolution Mechanism Report," described in part in Section 1300.71(q) of this regulation, on an electronic form to be supplied by the Department Managed Health Care pursuant to section 1300.41.8 of title 28 containing the following, which shall be reported based upon the date of receipt of the provider dispute or amended provider dispute:

(1) Information on the number and types of providers using the dispute resolution mechanism;

(2) A summary of the disposition of all provider disputes, which shall include an informative description of the types, terms and resolution. Disputes contained in a bundled submission shall be reported separately as individual disputes. Information may be submitted in an aggregate format so long as all data entries are appropriately footnoted to provide full and fair disclosure; and

(3) A detailed, informative statement disclosing any emerging or established patterns of provider disputes and how that information has been used to improve the plan's administrative capacity, plan-provider relations, claim payment procedures, quality assurance system (process) and quality of patient care (results) and how the information has been used in the development of appropriate corrective action plans. The information provided pursuant to this paragraph shall be submitted with, but separately from the other portions of the Annual Plan Claims Payment and Dispute Resolution Mechanism Report and may be accompanied by a cover letter requesting confidential treatment pursuant section 1007 of title 28.

(4) The first report shall be due on or before January 15,2005.

(*l*) Confidentiality.

(1) The plan's Annual Plan Claims Payment and Dispute Resolution Mechanism Report to the Department regarding its dispute resolution mechanism shall be public information except for information disclosed pursuant to section (k)(3) above, that the Director, pursuant to a plan's written request, determines should be maintained on a confidential basis.

(2) The plan's quarterly disclosures pursuant to section 1300.71(q)(1) shall be public information except for the information relating to the plan's corrective action strategies that the Director, pursuant to a plan's written request, determines should be maintained on a confidential basis.

(m) Review and Enforcement.

(1) The Department shall review the plan's and the plan's capitated provider's provider dispute resolution mechanism(s), including the records of provider disputes filed with the plan and remedial action taken pursuant to section 1300.71.38(m)(3), through medical surveys and financial examinations under sections 1380, 1381 or 1382 of the Health and Safety Code, and when appropriate, through the investigation of complaints of unfair provider dispute resolution mechanism(s).

(2) The failure of a plan to comply with the requirements of this regulation shall be a basis for disciplinary action against the plan. The civil, criminal, and administrative remedies available to the Director under the Health and Safety Code and this regulation are not exclusive, and may be sought and employed in any combination deemed advisable by the Director to enforce the provisions of this regulation.

(3) Violations of the Act and this regulation are subject to enforcement action whether or not remediated, although a plan's self-identification and self-initiated remediation of violations or deficiencies may be considered in determining the appropriate penalty.

NOTE: Authority cited: Sections 1344 and 1371.38, Health and Safety Code. Reference: Sections 1367, 1371 and 1371.38, Health and Safety Code.

HISTORY:

1. New section filed 7-24-2003; operative 8-23-2003 (Register 2003, No. 30).

§ 1300.71.39. Unfair Billing Patterns.

(a) Except for services subject to the requirements of Section 1367.11 of the Act, "unfair billing pattern" includes the practice, by a provider of emergency services, including but not limited to hospitals and hospital-based physicians

such as radiologists, pathologists, anesthesiologists, and on-call specialists, of billing an enrollee of a health care service plan for amounts owed to the provider by the health care service plan or its capitated provider for the provision of emergency services.

(b) For purposes of this section:

(1) "Emergency services" means those services required to be covered by a health plan pursuant to Health & Safety Code sections 1345(b)(6), 1367(i), 1371.4, 1371.5 and Title 28, California Code of Regulations, sections 1300.67(g) and 1300.71.4.

(2) Co-payments, coinsurance and deductibles that are the financial responsibility of the enrollee are not amounts owed the provider by the health care service plan.

(3) "The plan's capitated provider" shall have the same meaning as that provided in section 1300.71(a).

NOTE: Authority cited: Sections 1344, 1371.39 and 1371.4, Health and Safety Code. Reference: Sections 1317.1, 1317.7, 1342, 1345, 1346, 1362.8, 1367, 1371, 1371.1, 1371.35, 1371.36, 1371.38, 1371.39, 1371.4, 1371.5 and 1379, Health and Safety Code.

HISTORY:

1. New section filed 9-15-2008; operative 10-15-2008 (Register 2008, No. 38).

§ 1300.73.21. Arbitration and Settlement Agreements.

(a) All health care service plans (plans) shall ensure that all arbitration decisions involving the plan and a current or former enrollee shall be provided to the Department as follows:

(1) Within thirty (30) days of receiving a written arbitration decision, the plan shall provide a copy of the complete arbitration decision to the Department. The complete arbitration decision shall have no part of the decision altered or redacted. The complete arbitration decision shall indicate the prevailing party, the amount and other relevant terms of any award, and the reasons for the decision.

(2) On a quarterly basis, plans shall provide the Department with redacted copies of all written arbitration decisions. The plan shall be responsible for redacting the written arbitration decisions ensuring that the names of the enrollee, the plan, witnesses, attorneys, providers, plan employees and health facilities have been removed from the decision. The redacted arbitration decisions will be available for public inspection on the Department's web page (www.dmhc.ca.gov).

(b) Every written arbitration decision, and every written settlement agreement resolving any dispute between a plan and a current or former enrollee shall contain the following language in bold, twelve (12) point type:

Nothing in this arbitration decision (or settlement agreement) prohibits or restricts the enrollee from discussing or reporting the underlying facts, results, terms and conditions of this decision (or settlement agreement) to the Department of Managed Health Care.

(c) All health care service contracts containing an arbitration clause; all arbitration agreements and decisions; and all settlement agreements resolving any dispute between a plan and a current or former enrollee, shall contain no language that expressly or impliedly prohibits the enrollee from discussing or reporting the underlying facts, outcome, results or decision with the Department.

(d) For purposes of this section, a "settlement agreement" shall be broadly construed to include any writing resolving a dispute between a plan and a current or former enrollee wherein the nature of the dispute relates to services, benefits, treatment or other rights and obligations created pursuant to the

enrollee and plan's contract for health care coverage, and includes settlements reached in, but not limited to, a mediation, arbitration, or other alternative dispute resolution process, or any civil lawsuit.

NOTE: Authority Cited: Sections 1344, 1346 and 1373.21, Health and Safety Code. Reference: Sections 1373.19 and 1373.20, Health and Safety Code.

HISTORY:

1. New section filed 8-19-2002; operative 9-18-2002 (Register 2002, No. 34).

§ 1300.74.16. Standing Referral to HIV/AIDS Specialist.

(a) The definitions and requirements of this section are applicable only to standing referrals made pursuant to Section 1374.16 of the Act. Nothing in this section requires an enrollee to transfer to a different primary care provider or limits referral authorizations that are not subject to Section 1374.16 of the Act.

(b) For the purposes of this section "AIDS" means Acquired Immunodeficiency Syndrome.

(c) For the purposes of this section "category 1 continuing medical education" means:

(1) For physicians, continuing medical education courses recognized as qualifying for category 1 credit by the Medical Board of California;

(2) For nurse practitioners, continuing education contact hours recognized by the California Board of Registered Nursing;

(3) For physician assistants, continuing education units approved by the American Association of Physician Assistants or those described in either subsection (c)(1) or (c)(2), above.

(d) For the purposes of this section "HIV" means the Human Immunodeficiency Virus.

(e) For the purposes of this section an "HIV/AIDS specialist" means a physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following four criteria:

(1) Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; or

(2) Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; or

(3) Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:

(A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and

(B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or

(4) Meets the following qualifications:

(A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and

(B) Has completed any of the following:

1. In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or

2. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or

3. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.

(f) When authorizing a standing referral to a specialist pursuant to Section 1374.16(a) of the Act for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, a health care service plan must refer the enrollee to an HIV/AIDS specialist. When authorizing a standing referral to a specialist for purposes of having that specialist coordinate the enrollee's health care pursuant to Section 1374.16(b) of the Act for an enrollee who is infected with HIV, a health care service plan must refer the enrollee to an HIV/AIDS specialist. The HIV/AIDS specialist may utilize the services of a nurse practitioner or physician assistant if:

(1) The nurse practitioner or physician assistant is under the supervision of an HIV/AIDS specialist; and

(2) The nurse practitioner or physician assistant meets the qualifications specified in subsection (e)(4); and

(3) The nurse practitioner or physician assistant and that provider's supervising HIV/AIDS specialist have the capacity to see an additional patient.

(g) Subsection (f) does not require a health care service plan to refer an enrollee to any provider who is not employed by or under contract with the health care service plan to provide health care services to its enrollees, unless there is no HIV/AIDS specialist, or appropriately qualified nurse practitioner or physician assistant under the supervision of an HIV/AIDS specialist, within the plan's network appropriate to provide care to the enrollee, as determined by the primary care physician in consultation with the plan medical director.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1344 and 1374.16, Health and Safety Code.

HISTORY:

1. Renumbering of former section 1300.67.60 to new section 1300.74.16, including repealer of subsections (h)-(i), filed 1-10-2008; operative 2-9-2008 (Register 2008, No. 2).

§ 1300.74.30. Independent Medical Review System.

(a) Plan enrollees may request independent medical review pursuant to this regulation for decisions that are eligible for independent medical review under Article 5.55 and section 1370.4 of the Act. The independent medical review process shall resolve decisions that deny, modify, or delay health care services, that deny reimbursement for urgent or emergency services or that involve experimental or investigational therapies. Specialized plans shall provide for independent medical reviews under this section if a covered service relates to the practice of medicine or is provided pursuant to a contract with a health plan providing medical, surgical and hospital services. The Department shall be the final arbiter when there is a question as to whether a dispute over a health care service is eligible for independent medical review, and whether

extraordinary and compelling circumstances exist that waive the requirement that the enrollee first participate in the plan's grievance system.

(b) An enrollee may apply for an independent medical review under the conditions specified in Section 1374.30(j) of the Act. The Department may waive the requirement that the enrollee participate in the plan's grievance process if the Department determines that extraordinary and compelling circumstances exist, which include, but are not limited to, serious pain, the potential loss of life, limb or major bodily function, or the immediate, and serious deterioration of the health of the enrollee.

(c) In cases involving a claim for out of plan emergency or urgent services that a provider determined were medically necessary, the independent medical review shall determine whether the services were emergency or urgent services necessary to screen and stabilize the enrollee's condition. For purposes of this section "emergency services" are services for emergency medical conditions as defined in section 1300.71.4 of title 28, and "urgent services" are all services, except emergency services, where the enrollee has obtained the services without prior authorization from the plan, or from a contracting provider.

(d) Applications for independent medical review shall be submitted on a one-page form entitled Independent Medical Review Application (DMHC IMR 11/00), which is incorporated by reference, and shall be provided by the Department. The form shall contain a signed release from the enrollee, or a person authorized pursuant to law to act on behalf of the enrollee, authorizing release of medical and treatment information. Additionally, the enrollee may provide any relevant material or documentation with the application including, but not limited to:

(1) A copy of the adverse determination by the plan or contracting provider notifying the enrollee that the request for health care services was denied, delayed or modified, in whole or in part, based on the determination that the service was not medically necessary;

(2) Medical records, statements from the enrollee's provider or other documents establishing that the dispute is eligible for review;

(3) A copy of the grievance requesting the health care service or benefit filed with the plan or any entity with delegated authority to resolve grievances, and the response to the grievance, if any;

(4) If expedited review is requested for a decision eligible for independent medical review pursuant to Article 5.55 of the Act, the application shall include, a certification from the enrollee's physician or provider indicating that an imminent and serious threat to the health of the enrollee exists. If expedited review is requested for a decision eligible for independent medical review pursuant to section 1370.4 of the Act, the application shall include a certification from the enrollee's physician that the proposed therapy would be significantly less effective if not promptly initiated.

(e) If additional information is needed to complete an application or to determine the enrollee's eligibility for independent medical review, the Department shall advise the enrollee or the enrollee's representative, the enrollee's provider, the enrollee's health care plan or the enrollee's attending physician, as appropriate, by the most efficient means available.

(f) The Department shall evaluate complaints received under subsection (b) of Section 1368 of the Act and applications submitted under this regulation and determine whether the enrollee is eligible for an independent medical review. The Department's determination will consider all information provided to the Department, the enrollee's medical condition and the disputed health care service. If the Department determines that the case should not be referred

to independent medical review, the request shall be considered a complaint under subsection (b) of Section 1368 and sections 1300.68 and 1300.68.01. The enrollee or the enrollee's representative, health plan and any involved provider shall be advised of the Department's determination.

(1) The request for independent medical review shall be filed with the Department within six months of the plan's written response to the enrollee's grievance. The six-month period does not begin to run until the enrollee, or the enrollee's representative, has been properly notified in writing of the plan's resolution of the grievance. Applications will not be rejected as untimely solely because the enrollee, the enrollee's provider, or the plan failed to submit supporting documentation. Requests for extensions or late applications shall be approved if a timely submission was reasonably impaired by inadequate notice of the independent medical review process or by the applicant's medical circumstances.

(2) An application will not be eligible for independent medical review if the enrollee's complaint has previously been submitted and reviewed by the Department. Exceptions may be approved if the application for independent medical review includes medical records and a statement from the enrollee's physician or provider demonstrating significant changes in the enrollee's medical condition or in medical therapies available have occurred since the Department's disposition of the complaint.

(3) Enrollees of Medi-Cal health care service plans are eligible for an independent medical review if the enrollee has not presented the disputed health care service for resolution by the Medi-Cal fair hearing process. Reviews shall be conducted in accordance with the statutes and regulations of the Medi-Cal program.

(4) This regulation applies to Medicare enrollees, to the extent the regulation does not conflict with federal law, including 42 USCS §1395w-26 (2004).

(g) Except for Medi-Cal enrollees, and Medicare enrollees exempted by federal law, as described at subsection (f)(4), the independent medical review system established pursuant to this section shall be the exclusive independent medical review process offered to enrollees for disputes involving the medical necessity of covered health care services. Nothing in this section shall preclude a health plan from offering other independent review processes for disputes that do not involve medical necessity.

(h) When the Department finds that a plan fails to advise an enrollee of the availability of independent medical review as required under Health and Safety Code section 1374.30(i), or engages in a practice of mischaracterizing determinations substantially based on medical necessity as coverage decisions, or otherwise interferes with the rights of enrollees to obtain independent medical review, the Department shall impose administrative penalties on the plan in accordance with the Act.

(i) The director shall notify the enrollee and the enrollee's health care plan if an application for independent medical review has been accepted within seven (7) calendar days of receipt of a completed application for a routine request and within 48 hours of receipt of a completed application for an expedited review. The notification shall identify the independent medical review organization, whether the review shall be conducted on an expedited or routine basis and other information deemed necessary by the Department. The director shall also transmit to the enrollee's health care plan a copy of the enrollee's signed release of medical and treatment information and copies of all other materials submitted with the enrollee's application.

(j) Following receipt of the Department's notification that an application for independent medical review has been assigned to an independent medical review

organization, the plan shall provide the organization with all information that was considered in relation to the disputed health care service, the enrollee's grievance and the plan's determination. The plan shall forward all information to the medical review organization within three (3) business days for a regular review and within one (1) calendar day in the case of an expedited review.

(1) Unless otherwise advised in the notification or by the assigned review organization, the plan shall submit a complete set of the materials described below for the independent review organization.

(A) A copy of all correspondence from and received by the plan concerning the disputed health care service, including but not limited to, any enrollee grievance relating to the requested service;

(B) A complete and legible copy of all medical records and other information used by the plan in making its decision regarding the disputed health care service. An additional copy of medical records shall be submitted for each reviewer.

(C) A copy of the cover page of the evidence of coverage and complete pages with the referenced sections highlighted or underlined sections, if the evidence of coverage was referenced in the plan's resolution of the enrollee's grievance;

(D) The plan's response to any additional issues raised in the enrollee's application for independent medical review.

(2) The plan shall promptly provide the enrollee with an annotated list of all documents submitted to the independent medical review organization, together with information on how copies may be requested.

(k) Plans shall be responsible for providing additional information as follows:

(1) Any medical records or other relevant matters not available at the time of the Department's initial notification, or that result from the enrollee's on-going medical care or treatment for the medical condition or disease under review. Such matters shall be forwarded as soon as possible upon receipt by the health plan, not to exceed five (5) business days in routine cases or one (1) calendar day in expedited cases.

(2) Additional medical records or other information requested by the IMR organization shall be sent within five (5) business days in routine cases or one (1) calendar day in expedited cases. In expedited reviews, the health care plan shall immediately notify the enrollee and the enrollee's health care provider by telephone or facsimile to identify and request the necessary information, followed by written notification, when the request involves materials not in the possession of the plan or its contracting providers.

(*l*) Each assigned reviewer shall issue a separate written analysis of the case, explaining the determination made, using plain English where possible. The analysis shall describe how the determination relates to the enrollee's medical condition and history, relevant medical records and other documents considered, and references to the specific medical and scientific evidence listed in Sections 1370.4(d) or 1374.33(b) of the Act, as applicable. For requests made pursuant to Article 5.55 of the Act, reviewers shall determine whether the disputed service is medically necessary for the enrollee. For requests made pursuant to section 1370.4 of the Act, the reviewers shall determine whether the requested therapy is likely to be more beneficial for the enrollee then other available standard therapies, and whether the plan shall provide the requested therapy. Reviews based on section 1300.70.4 of these regulations shall also reference the medical and scientific evidence considered in assessing whether the requested health care service is likely to be more beneficial than other available standard therapies. The analysis may also discuss the risks and benefits considered by the reviewer in considering proposed and standard treatments.

(m) The Department, the enrollee, or his/her representative may withdraw a case from the independent review system at any time. The plan may seek withdrawal of the case from the review system by providing the disputed health care service, subject to the concurrence of the enrollee.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1370.4, 1374.30 and 1374.33, Health and Safety Code.

HISTORY:

1. New section filed 2-18-2003; operative 3-20-2003 (Register 2003, No. 8).
2. New subsection (f)(4) and amendment of subsection (g) filed 7-25-2005; operative 8-24-2005 (Register 2005, No. 30).

§ 1300.74.72. Mental Health Parity.

(a) The mental health services required for the diagnosis, and treatment of conditions set forth in Health and Safety Code section 1374.72 shall include, when medically necessary, all health care services required under the Act including, but not limited to, basic health care services within the meaning of Health and Safety Code sections 1345(b) and 1367(i), and section 1300.67 of Title 28. These basic health care services shall, at a minimum, include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from licensed mental health providers including, but not limited to, psychiatrists and psychologists.

(b) A plan shall provide coverage for the diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72 through health care providers within the meaning of Health and Safety Code section 1345(i) who are:

(1) acting within the scope of their licensure, and

(2) acting within their scope of competence, established by education, training and experience, to diagnose, and treat conditions set forth in Health and Safety Code section 1374.72.

(c) A diagnosis within the meaning of Health and Safety Code section 1374.72 shall be made in accordance with professionally recognized diagnostic criteria including, but not limited to, the diagnostic criteria set forth in the Diagnostic and Statistical Manual for Mental Disorders — IV — Text Revision (June 2000).

(d) A preliminary or initial diagnosis made by a primary care physician, mental health provider or pediatrician meeting the requirements of subsection (b) above, that an enrollee has one or more of the conditions set forth in Health and Safety Code section 1374.72, shall constitute the diagnosis for the length of time necessary to make a final diagnosis, whether or not the final diagnosis confirms the preliminary or initial diagnosis.

(e) "Pervasive Developmental Disorders" shall include Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified (including Atypical Autism), in accordance with the Diagnostic and Statistical Manual for Mental Disorders — IV — Text Revision (June 2000).

(f) A plan's referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72 and for related health care services as appropriate upon referral from a primary care physician, mental health provider or pediatrician meeting the requirements of subsection (b) above.

(g) If a plan contracts with a specialized health care service plan for the purpose of providing Health and Safety Code section 1374.72 services, the following requirements shall apply:

(1) the specialized health care service plan shall maintain a telephone number that an enrollee may call during normal business hours to obtain information about benefits, providers, coverage and any other relevant information concerning an enrollee's mental health services;

(2) if the plan issues identification cards to enrollees, the identification cards shall include the telephone number required to be maintained above and a brief statement indicating that enrollees may call the telephone number for assistance about mental health services and coverage;

(3) the plan shall monitor the continuity and coordination of care that enrollees receive, and take action, when necessary, to assure continuity and coordination of care, in a manner consistent with professionally recognized evidence-based standards of practice, across the health care network;

(4) the plan shall monitor, as often as necessary, but not less frequently than once every year, the collaboration between medical and mental health providers including, but not limited to, the following:

(A) exchange of information,

(B) appropriate diagnosis, treatment and referral, and

(C) access to treatment and follow-up for enrollees with co-existing medical and mental health disorders;

(5) the plan shall retain full responsibility for assuring continuity and coordination of care, in accordance with the requirements of this subsection, notwithstanding that, by contract, it has obligated a specialized health care service plan to perform some or all of these activities.

(h) Nothing in this section shall be construed to mandate coverage of services that are not medically necessary or preclude a plan from performing utilization review in accordance with the Act.

(i) A plan shall include in its Evidence of Coverage or Combined Evidence of Coverage and Disclosure Form a list of mental conditions required to be covered pursuant to Health and Safety Code section 1374.72.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1345, 1367 and 1374.72, Health and Safety Code.

HISTORY:

1. New section filed 9-23-2003; operative 10-23-2003 (Register 2003, No. 39).

§ 1300.74.73. Pervasive Developmental Disorder and Autism Coverage.

Health plans subject to Section 1374.73 of the Act shall comply with this section.

(a) Requirements

(1) For health plans that provide hospital, medical or surgical coverage under contract with the Healthy Families Program or the Board of Administration of the California Public Employees' Retirement System, section 1374.73 of the Act does not affect, reduce or limit the obligation to provide coverage for the diagnosis and medically necessary treatment of pervasive developmental disorder (PDD) and autism, including medically necessary behavioral health treatment, pursuant to Health and Safety Code section 1374.72.

(2) Nothing in subdivision (a)(1) of this section shall be construed to mandate coverage of services that are not medically necessary or preclude a plan from performing utilization review in accordance with the Act.

(3) Each health plan that is subject to the requirements of section 1374.73 of the Act shall submit a report to the Department no later than December 31,2012, demonstrating that the health plan has an adequate network of qualified autism service providers, qualified autism service professionals and/or qualified autism service paraprofessionals. The required report shall include the following information:

(A) The name of each qualified autism service provider entity or organization/group, listed by county and zip code. For each identified qualified autism service provider entity or organization/group, state the following information:

1. The number of individual qualified autism service providers available to the entity or organization/group;

2. The number of qualified autism service professionals available to the entity or organization/group; and,

3. The number of qualified autism service paraprofessionals available to the entity or organization/group.

(B) The number of the health plan's individual qualified autism service providers, listed by county and zip code. For each qualified autism service provider identified, state the following information:

1. The number of qualified autism service professionals available to the qualified autism service provider pursuant to Health and Safety Code section 1374.73(c)(4)(B); and,

2. The number of qualified autism service paraprofessionals available to the qualified autism service provider pursuant to Health and Safety Code section 1374.73(c)(5)(A).

(C) A description of how the health plan is determining provider network adequacy, including how geographic accessibility and timely access for health plan enrollees to medically necessary PDD and autism health care services is being met. This information should include:

1. Data describing the adequacy of the health plan's provider network for each region or service area, including utilization data and information on the health plan's enrollee population, such as age, gender and other relevant factors used by the health plan; and,

2. A description of the health plan's system for monitoring and evaluating provider network adequacy in each region or service area.

(D) Upon request, the health plan shall submit within 30 calendar days any additional information the Director may request to determine the adequacy of the plan's network to ensure that health plan enrollees are receiving medically necessary PDD and autism health care services, including timely screening, diagnosis, evaluation and treatment.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1345, 1367, 1374.72 and 1374.73, Health and Safety Code.

HISTORY:

1. New section filed 9-6-2012 as an emergency; operative 9-6-2012 (Register 2012, No. 36). A Certificate of Compliance must be transmitted to OAL by 3-5-2013 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 9-6-2012 order transmitted to OAL 2-28-2013 and filed 4-8-2013 (Register 2013, No. 15).

ARTICLE 9
Financial Responsibility

Section

§ 1300.75. Agreements with Subsequent Providers. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Stats. 1978, Ch. 285.

HISTORY:
1. Repealer filed 9-27-79; effective thirtieth day thereafter (Register 79, No. 39).

§ 1300.75.1. Fiscal Soundness, Insurance, and Other Arrangements.

(a) A plan shall demonstrate fiscal soundness and assumption of full financial risk as follows:

(1) Demonstrate through its history of operations and through projections (which shall be supported by a statement as to the facts and assumptions upon which they are based) that the plan's arrangements for health care services and the schedule of its rates and charges are financially sound, and provide for the achievement and maintenance of a positive cash flow, including provisions for retirement of existing and proposed indebtedness.

(2) Demonstrate that its working capital is adequate, including provisions for contingencies.

(3) Demonstrate an approach to the risk of insolvency which allows for the continuation of benefits for the duration of the contract period for which payment has been made, the continuation of benefits to subscribers and enrollees who are confined on the date of insolvency in an in-patient facility until their discharge, and payments to unaffiliated providers for services rendered.

(b) As a part of its program pursuant to subsection (a), a plan may obtain insurance or make other arrangements:

(1) For the cost of providing to any member covered health care services the aggregate value of which exceeds $5,000 in any year;

(2) For the cost of covered health care services provided to its members other than through the plan because medical necessity required their provision before they could be secured through the plan; and

(3) For not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year.

(c) In passing upon a plan's showing pursuant to this section, the Director will consider all relevant factors, including but not limited to:

(1) The method of compensating providers and the terms of provider contracts, especially as to the obligations of providers to subscribers and enrollees in the event of plan insolvency.

(2) The methods by which the plan controls and monitors the utilization of health care services.

(3) The administrative expenses (actual and projected) of the plan and especially as to new or expanding plans, the fiscal soundness of its program to acquire and service an expanded subscriber population.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1375.1, Health and Safety Code.

HISTORY:

1. Repealer and new section filed 9-27-79; effective thirtieth day thereafter (Register 79, No. 39).
2. Amendment filed 12-8-82; effective thirtieth day thereafter (Register 82, No. 50).
3. Change without regulatory effect amending subsection (c) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.75.2. Plan As Subsequent Provider. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Stats. 1978, Ch. 285.

HISTORY:

1. Repealer filed 9-27-79; effective thirtieth day thereafter (Register 79, No. 39).

§ 1300.75.3. Subsequent Provider Exemption. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Stats. 1978, Ch. 285.

HISTORY:

1. Repealer filed 9-27-79; effective thirtieth day thereafter (Register 79, No. 39).

RISK-BEARING ORGANIZATIONS

§ 1300.75.4. Definitions.

As used in these Solvency Regulations:

(a) "External party" means the Department of Managed Health Care or its designated agent, which may be contracted or appointed to fulfill the functions stated in these Solvency Regulations. Whenever these Solvency Regulations reference the Department of Managed Health Care it shall mean the Department of Managed Health Care (Department) or its designated agent.

(b) "Organization" means a risk-bearing organization as defined in Health and Safety Code Section 1375.4(g). An organization includes an entity that contracts directly with the plan or subcontracts with another organization to arrange for the health care services of a plan's enrollees and meets the requirements of Health and Safety Code section 1375.4(g).

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

(d) "Risk arrangement" 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 the organization shares the risk of financial gain or loss with the plan.

(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 sections 1300.75.4 through 1300.75.4.8 of Title 28 of the California Code of Regulations.

(f) "Cash-to-claims ratio" is an organization's cash, readily available marketable securities and HMO capitation receivables due within thirty (30) days, divided by the organization's unpaid claims (claims payable and incurred but not reported [IBNR] claims) liability. The organization shall report only those HMO capitation receivables due within thirty (30) days the organization reasonably believes will be received by that time.

(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 or other claims payment deficiencies, determined through the Department'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 sections 1375.4(b)(1)(A)(i), (ii), (iii), and (iv) and the cash-to-claims ratio as defined in subsection (f) above.

(i) "In a manner that does not adversely affect the integrity of the contract negotiation process" means the disclosure of an organization's financial data submissions in a format that does not impair the organization's ability to negotiate its contracts for the delivery of health care services or does not allow a contracting party to calculate: (1) an organization's precise profit/loss margins on any line of business, or (2) the rates that the organization has negotiated with any contracting entity or vendor during a prior accounting period.

(j) "Sponsoring organization" shall have the same meaning as Health and Safety Code section 1375.4(b)(1)(B).

(k) "Sub-delegating organization" means an organization that delegates any portion of the responsibility for providing or arranging for the health care services of a plan's enrollees to another organization on a capitated or fixed period payment basis.

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

HISTORY:

1. New section filed 3-22-2001 as an emergency; operative 3-22-2001 (Register 2001, No. 12). A Certificate of Compliance must be transmitted to OAL by 7-20-2001 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 3-22-2001 order, including amendment of subsection (d)(1), transmitted to OAL 7-20-2001 and filed 8-31-2001 (Register 2001, No. 35).
3. Amendment of first paragraph and subsections (a)-(e) and new subsections (f)-(i) filed 8-10-2005; operative 9-9-2005 (Register 2005, No. 32).
4. Change without regulatory effect amending subsection (i) filed 12-14-2005 pursuant to section 100, title 1, California Code of Regulations (Register 2005, No. 50).
5. Amendment of subsections (a)-(b) and (f) and new subsections (j)-(k) filed 7-10-2019; operative 10-1-2019 (Register 2019, No. 28).

§ 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.

(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.

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

HISTORY:

1. New section filed 3-22-2001 as an emergency; operative 3-22-2001 (Register 2001, No. 12). A Certificate of Compliance must be transmitted to OAL by 7-20-2001 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 3-22-2001 order, including amendment section, transmitted to OAL 7-20-2001 and filed 8-31-2001 (Register 2001, No. 35).
3. Amendment filed 7-10-2019; operative 10-1-2019 (Register 2019, No. 28).

§ 1300.75.4.2. Organization Information.

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

(a) Maintain at all times a minimum "cash-to-claims ratio," as defined in section 1300.75.4(f), of 0.75 except as specified below. Beginning October 1,2019 and ending on October 1,2020, an organization shall comply with the cash-to-claims ratio definition, which is defined as an organization's cash, readily available marketable securities and receivables, excluding all risk pool, risk-

sharing, incentive payment program and pay-for-performance receivables, reasonably anticipated to be collected within sixty (60) days divided by the organization's unpaid claims (claims payable and incurred but not reported (IBNR) claims) liability.

(b) DMHC Quarterly Financial Survey Report Form ("quarterly financial survey report"). For each quarter, submit to the Department, not more than forty-five (45) days after the close of each quarter of the fiscal year, a quarterly financial survey report on the DMHC Quarterly Financial Survey Report Form, dated September,2018, as incorporated herein by reference, and published by the Department on its webpage: www.dmhc.ca.gov. The DMHC Quarterly Financial Survey Report Form shall be filed pursuant to section 1300.41.8 of Title 28, California Code of Regulations, and shall contain all of the following information:

(1) Quarterly financial survey report information (including the following: a balance sheet; an income statement; a statement of cash flows; a statement of net worth; cash and cash equivalent; receivables and payables; risk pool and other incentives; claims aging; notes to financial statements; enrollment information; mergers, acquisitions and discontinued operations; the incurred but not reported (IBNR) methodology; and administrative expenses), 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 and year-to-date, 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.

(A) Sub-delegating organizations shall list all contracting organizations, including their names, addresses, contact persons, telephone numbers, and number of enrollees assigned to the organization as of the last day of the quarter being reported.

(B) Quarterly financial survey reports of an organization required pursuant to these rules shall be on a combining basis with an affiliate, if either the organization or such affiliate is legally or financially responsible for the payment of the organization's claims. Any affiliated entity included in this report shall be separately identified and reported in a combining schedule format. Upon the request of the Director, the organization or affiliate subject to this subdivision shall provide financial statements on a separate DMHC Quarterly Financial Survey Report Form. The Director shall consider at least the following information when determining whether to make the request:

(i) Whether financial solvency concerns exist with the organization or the affiliate, which impact the organization's ability to maintain compliance with the Grading Criteria or processing and paying claims in compliance with Claims Settlement Practices as detailed in section 1300.71 of Title 28, California Code of Regulations;

(ii) Whether there are concerns regarding the transparency of the affiliate relationship; and,

(iii) Whether financial documentation is not presented in accordance with GAAP.

(C) For the purposes of this section, an organization's use:

(i) Of a "sponsoring organization" arrangement to reduce its liabilities for the purposes of calculating tangible net equity, working capital, and cash-to-claims ratio; or

(ii) An affiliated entity to provide claims processing services shall not be construed to automatically create a legal or financial obligation to pay the claims liability for the health care services for enrollees.

(2) 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 settlement practices and timeliness.

(3) A statement as to whether or not:

(A) 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

(B) 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:

(i) To estimate and document, on a monthly basis, its liability for IBNR claims; or

(ii) To maintain its books and records on an accrual 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 (4) below.

(4) 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(c) 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, that excludes unsecured affiliate receivables except those arising in the normal course of business which are payable on the same terms as equivalent transactions with non-affiliates. If the required TNE, cash-to-claims ratio, 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.

(A) The organization may reduce its liabilities or increase its cash for purposes of calculating its TNE, working capital and cash-to-claims ratio in a manner allowed by Health and Safety Code section 1375.4(b)(1)(B) and this section so long as the sponsoring organization has filed with the Department:

(i) Its audited annual financial statements within one-hundred and twenty (120) days of the end of the sponsoring organization's fiscal year; and

(ii) 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 lesser amount in situations where the organization can demonstrate to the Director's satisfaction and written approval that a lesser amount of TNE is sufficient. If an organization has a sponsoring organization, the organization

shall provide information to the Department 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).

a. An organization may rely on a sponsoring organization for no more than one (1) fiscal year to reduce the organization's liabilities or increase its cash for purposes of calculating its TNE, working capital and cash-to-claims ratio. Requests by an organization to extend the one (1) year period and to rely on a sponsoring organization during a subsequent period shall be submitted to the Department and may be approved at the Director's discretion. Only a single twelve (12) month extension of the use of a sponsoring organization may be requested by the organization. The Director shall consider at least the following information when determining whether to grant the request:

1. Financial projections demonstrating the compliance timeframes outlined by the organization;

2. Specific actions taken and proposed by the organization to improve financial solvency; and,

3. Any modifications or changes to the guarantee provided by the sponsoring organization.

b. An organization shall apply to the Department to request the use of a sponsoring organization. The application shall include projections showing how the organization will obtain and maintain compliance with requirements of Health and Safety Code section 1375.4(b)(1)(A) once the guarantee from the sponsoring organization terminates.

c. If the period that an organization has a sponsoring organization is longer than twelve (12) months, the organization shall annually, from the date of the sponsoring organization contract, report to the Department projections showing how the organization will obtain and maintain compliance with the requirements of Health and Safety Code section 1375.4(b)(1)(A) once the guarantee from the sponsoring organization terminates.

(5) 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.

(c) DMHC Annual Financial Survey Report Form ("annual financial survey report"). An organization shall submit to the Department, not more than one hundred fifty (150) days after the close of the organization's fiscal year 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 on the DMHC Annual Financial Survey Report Form, dated September 2018, as incorporated herein by reference and published by the Department on its webpage: www.dmhc.ca.gov. The DMHC Annual Financial Survey Report Form shall be filed pursuant to section 1300.41.8 of Title 28 of the California Code of Regulations, and shall be based upon the organization's annual audited financial statement prepared in accordance with generally accepted accounting principles (GAAP). The annual financial survey report shall contain all of the following:

(1) Annual financial survey report, based upon the organization's annual audited financial statements (including at least the following: a balance sheet; an income statement; a statement of cash flows; a statement of net worth; cash

and cash equivalent; receivables and payables; risk pool and other incentives; claims aging; notes to financial statements; enrollment information; mergers, acquisitions and discontinued operations; the incurred but not reported (IBNR) methodology; administrative expenses; 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.

(A) A sub-delegating organization shall include the allocation of risk between the sub-delegating organization and each organization with which it contracts and shall disclose whether the sub-delegating organization provides stop-loss coverage to the organization, and if so, the nature of all stop-loss arrangements.

(B) Annual financial survey reports of an organization required pursuant to these Solvency Regulations shall be on a combining basis with an affiliate if either the organization or such affiliate is legally or financially responsible for the payment of the organization's claims. Any affiliated entity included in the report shall be separately identified. Upon the request of the Director, the organization or affiliate subject to this subdivision shall provide financial statements on a separate DMHC Annual Financial Survey Report Form. The Director shall consider at least the following information when determining whether to make the request:

(i) Whether financial solvency concerns exist with the organization or the affiliate, which impact the organization's ability to maintain compliance with the Grading Criteria or processing and paying claims in compliance with Claims Settlement Practices as detailed in section 1300.71 of Title 28, California Code of Regulations;

(ii) Whether there are concerns regarding the transparency of the affiliate relationship; and,

(iii) Whether financial documentation is not presented in accordance with GAAP.

(C) For the purposes of this section, an organization's use of:

(i) A "sponsoring organization" arrangement to reduce its liabilities for the purposes of calculating TNE and working capital, cash-to-claims ratio; or

(ii) An affiliated entity to provide claims processing services shall not be construed to automatically create a legal or financial obligation to pay claims liability for health care services for enrollees.

(D) When combined financial statements are required by this regulation, the independent accountant's report or opinion shall 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.

(i) 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.

(E) 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.

(2) 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:

(A) To estimate and document, on a monthly basis, its liability for IBNR claims; or

(B) To maintain its books and records on an accrual 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)(A) below.

(3) 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(c) of Title 28, California Code of Regulations; and has, at all times during the year, maintained positive working capital, calculated in a manner consistent with GAAP, that excludes unsecured affiliate receivables except those arising in the normal course of business which are payable on the same terms as equivalent transactions with non-affiliates. If either the required TNE, cash-to-claims ratio, 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.

(A) 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) and this section, so long as the sponsoring organization has filed with the Department:

(i) Its audited annual financial statements within one-hundred and twenty (120) days of the end of the sponsoring organization's fiscal year and

(ii) 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 lesser amount in situations where the organization can demonstrate to the Director's satisfaction and written approval that a lesser amount of TNE is sufficient. If an organization has a sponsoring organization, the organization shall provide information to the Department 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).

a. An organization may rely on a sponsoring organization for no more than one (1) fiscal year to reduce the organization's liabilities or increase its cash for purposes of calculating its TNE, working capital and cash-to-claims ratio. Requests by an organization to extend the one (1) year period and to rely on a sponsoring organization during a subsequent period shall be submitted to the Department and may be approved at the Director's discretion. Only a single twelve (12) month extension of the use of a sponsoring organization may be requested by the organization. The Director shall consider at least the following information when determining whether to grant the request:

1. Financial projections demonstrating the compliance timeframes outlined by the organization;

2. Specific actions taken and proposed by the organization to improve financial solvency; and,

3. Any modifications or changes to the guarantee provided by the sponsoring organization.

b. An organization shall apply to the Department to request the use of a sponsoring organization. The application shall include projections showing how the organization will obtain and maintain compliance with the requirements of Health and Safety Code section 1375.4(b)(1)(A) once the guarantee from the sponsoring organization terminates.

c. If the period that an organization has a sponsoring organization is longer than twelve (12) months, the organization shall annually, from the date of the sponsoring organization contract, report to the Department projections showing how the organization will obtain and maintain compliance with the requirements of Health and Safety Code section 1375.4(b)(1)(A) once the guarantee from the sponsoring organization terminates.

(4) 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.

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

(6) The annual financial survey report shall include, as an attachment, a copy of the complete annual audited financial statement, including footnotes and the certificate or opinion of the independent certified public accountant.

(d) Statement of Organization Survey. Submit to the external party, a "Statement of Organization," in an electronic format, prepared by the Department, 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;

(6) The name, business 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.

(A) Next to each listed category in the matrix, a disclosure of the primary 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, if available, 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) Provide any other information that the Director deems reasonable and necessary, as permitted by law, 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, if the report is a combined report, a principal officer of the affiliate, and signed by both principal officers, as defined by section 1300.45(o) of Title 28, California Code of Regulations. This verification shall be submitted by delivering a hard copy with an original signature to the Director, care of the Office of Financial Review, Department of Managed Health Care, 980 Ninth Street, Suite 500, Sacramento, CA 95814.

(f) Notify the Department and each contracting health plan or sub-delegating organization 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. Each sub-delegating organization shall have adequate procedures in place to ensure the Department of Managed Health Care or its designated agent is notified no later than five (5) business days from discovering that any of its contracting organizations experienced any event which materially alters the organization's financial situation, or threatens its solvency.

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

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

HISTORY:

1. New section filed 8-10-2005; operative 9-9-2005 (Register 2005, No. 32). For prior history, see Register 2002, No. 28.
2. Amendment filed 7-10-2019; operative 10-1-2019 (Register 2019, No. 28).

§ 1300.75.4.3. Plan Reporting.

(a) Plan Quarterly Survey. Every plan that contracts with an organization shall, by May 15,2001, and not more than forty-five (45) days after the close of each subsequent calendar quarter, submit a quarterly survey report in an electronic format to the Director listing all its contracting organizations, including their names, addresses, contact persons, telephone numbers, and

number of enrollees assigned to the organization as of the last day of the quarter being reported.

(b) Plan Annual Survey. Along with the quarterly report due May 15,2001, and for the report due by May 15 of each subsequent year (i.e., an annual reporting period), every plan shall submit an annual survey report in an electronic format to the Director, containing the following information, as of December 31 of the prior calendar year, for each organization with which the plan has a risk arrangement:

(1) For the plan's commercial, Medicare+Choice, and Medi-Cal product lines, the report shall disclose, in a separate matrix for each product line, the allocation of risk between the plan, the organization, and the facility by major expense category. For each of the plan's commercial, Medicare+Choice, and Medi-Cal product lines, the report shall disclose the number of covered lives and the counties primarily served by the organization.

(2) The report shall disclose whether the plan provides stop-loss insurance to the organization, and if so, the nature of any and all stop-loss arrangements.

(c) Each quarterly and annual survey report and matrix submitted to the Department shall include a written verification stating that the plan has complied with all the risk arrangement disclosure requirements of section 1300.75.4.1 and that the survey report or matrix is true and correct to the best knowledge and belief of a principal officer of the plan, and signed by a principal officer, as defined by regulation 1300.45(o) of Title 28 of the California Code of Regulations.

(d) Upon request, the plan shall provide any additional information that the Director may from time to time require to understand the type, amount, or appropriateness, of the financial risk assumed by the plan's contracting organizations.

(e) Every plan that contracts with an organization shall have adequate procedures in place to ensure that the plan notifies the Department of Managed Health Care or its designated agent no later than five (5) business days from discovering that any of its contracting organizations experienced any event which materially alters the organization's financial situation, or threatens its solvency.

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

HISTORY:

1. New section filed 3-22-2001 as an emergency; operative 3-22-2001 (Register 2001, No. 12). A Certificate of Compliance must be transmitted to OAL by 7-20-2001 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 3-22-2001 order, including amendment section, transmitted to OAL 7-20-2001 and filed 8-31-2001 (Register 2001, No. 35).

§ 1300.75.4.4. Confidentiality.

(a) Financial and other records produced, disclosed or otherwise made available by an organization 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 the Director makes a specific finding that the information can be released in a manner that does not adversely affect the integrity of the contract negotiation process; except that the organization's annual audited financial statement as required by section 1300.75.4.2(c) shall be permanently maintained on a confidential basis.

(b) The Director has determined that the disclosure of the following information in the format provided below will not adversely affect the integrity of an organization's contract negotiation process and, therefore, will be made available to the public as follows:

(1) Within 120 days following each reporting period due date, the Department of Managed Health Care (Department) will make the following information available, on its website, 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 or not met each of the Grading Criteria, as follows:

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 disclosure of whether the organization has implemented and is compliant with a final CAP designed to remedy any deficiencies reported in the Grading Criteria;

4. The relative working capital of each organization, consistent with section 1300.75.4(h), presented as a ratio of current assets divided by current liabilities;

5. The relative tangible net equity (TNE) of each organization, consistent with section 1300.75.4(h), presented as a ratio of tangible net assets divided by total liabilities;

6. Claims payment timeliness in a percentage format, consistent with section 1300.75.4.(h), reflecting the amount of claims that the organization is paying on a timely basis; and,

7. To the extent feasible, each financial item described in paragraphs 1. through 5. shall be presented for both the current and the four previous reporting periods, following the effective date of these regulations.

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

(D) All information contained in the Statement of Organization of a risk-bearing organization, except responses to sections 1300.75.4.2(d)(8)(A), (d)(14) and financial documentation provided pursuant to section 1300.75.4.2 (d)(4); and

(E) Comparative, aggregated data on all organizations, and information that enables consumers to assess an organization's relative financial viability in a format that does not identify any individual organizations and consistent with section 1300.75.4.4 of Title 28, California Code of Regulations.

(c) Information received and maintained on a confidential basis pursuant to this section may be disclosed by the Director 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 to enforce the provisions of the Knox-Keene Act;

(3) In the event that an organization publicly questions or challenges the Department's decision to approve or disapprove an organization's proposed CAP submitted in accordance with section 1300.75.4.8 of Title 28 of the California Code of Regulations, the Department may release the relevant portions of the organization's financial information to explain the Department's decision; and,

(4) Upon a determination by the Director, pursuant to Health and Safety Code section 1375.4(b)(7), that the justification for the confidential treatment no longer exists, provided that the information that is disclosed is at least two (2) years old.

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

HISTORY:

1. New section filed 8-10-2005; operative 9-9-2005 (Register 2005, No. 32). For prior history, see Register 2002, No. 28.

§ 1300.75.4.5. Plan and Sub-Delegating Organization Compliance.

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

(1) That plan or sub-delegating organization personnel review all reports and financial information made available pursuant to Health and Safety Code section 1375.4, these Solvency Regulations, and as provided under the terms of the contract with an organization 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) of Title 28, California Code of Regulations;

(2) Appropriate action(s) are taken following the Department's written notification to an organization's contracting health plan(s) or sub-delegating organization(s) that the organization has:

(A) Failed to substantially comply with the reporting obligations specified in section 1300.75.4.2 of 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) Refused to permit the activities of the Department as specified in Health and Safety Code section 1375.4 or in these Solvency Regulations; or,

(C) Failed to substantially comply with the requirements of a final CAP for a period of more than ninety (90) days, as determined by the Department.

(3) Appropriate action shall include, but is not limited to, a prohibition on the assignment or addition of any additional enrollees to the risk arrangement with that organization without the prior written approval of the Director. The prohibition on assignments of additional enrollees to an organization pursuant to subsection (2) 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. The prohibition on the assignment of additional enrollees shall take effect thirty (30) days after the date of Department's notification to the organization's contracting plan(s), and shall remain in effect until the Department notifies the organization's contracting health plan in writing that the organization's non-compliance has been remedied.

(4) The plan or sub-delegating organization complies with the corrective action process and cooperates in the implementation of a final CAP, as defined in section 1300.75.4.8, including, but not limited to, implementing contingency plans for continuous delivery of health care services to plan enrollees served by the organization.

(5) The plan or sub-delegating organization shall advise the Department and the organization in writing within five (5) days of becoming aware:

(A) that a contracting organization is not in compliance with the requirements of a final CAP, or

(B) that an organization's conduct may cause the plan to be subject to disciplinary action pursuant to Health and Safety Code section 1386.

(6) If a plan proposes to transfer plan enrollees receiving care from an organization that is compliant with a final CAP to alternative providers 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 Block Transfer Filing pursuant to Health and Safety Code section 1373.65. In addition to all other criteria for reviewing block transfers, the Director may disapprove, postpone or suspend the plan's proposed transfer of enrollees if the department reasonably determines:

(A) That the proposed reassignment of enrollees will likely cause the organization's failure or result in the organization ceasing operations within three (3) months;

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

(C) That the organization is not denying or delaying basic health care services or continuity of care for the plan's enrollees assigned to the organization.

(7) If a sub-delegating organization proposes to transfer plan enrollees receiving care from an organization that is compliant with a final CAP to alternative providers and the reassignment is based, in part, on the organization's failure to meet one (1) or more of the Grading Criteria, the sub-delegating organization shall notify the plan, prior to transferring enrollees from the organization, and the plan shall determine whether it is necessary to file with the Department a Block Transfer Filing pursuant to Health and Safety Code section 1373.65. In addition to all other criteria for reviewing block transfers, the Director may disapprove, postpone or suspend the sub-delegating organization's proposed transfer of enrollees if the Department reasonably determines:

(A) That the proposed reassignment of enrollees will likely cause the organization's failure or result in the organization ceasing operations within three (3) months;

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

(C) That the organization is not denying or delaying basic health care services or continuity of care for the plan's enrollees assigned to the organization.

(8) Notwithstanding subsection (6) and (7) of this section, nothing in these regulations shall limit or impair:

(A) 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;

(B) an enrollee's right to self-select a new provider; or

(C) the plan's ability to transfer individual enrollees assigned to a provider who terminates his/her relationship with the organization to ensure that the enrollee receives appropriate continuity of care.

(b) Every contract involving a risk arrangement between a plan and an organization and every contract involving a risk arrangement between a sub-

delegating organization 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. Neither a plan nor sub-delegating organization shall request or accept a waiver of any the contractual requirements set forth in these Solvency Regulations.

(c) Within thirty (30) days of notification pursuant to section 1300.75.4.5(a)(2)(C) of Title 28, California Code of Regulations, a plan or sub-delegating organization 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.

(d) 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 section 1386.

(e) 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.

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

HISTORY:

1. New section filed 3-22-2001 as an emergency; operative 3-22-2001 (Register 2001, No. 12). A Certificate of Compliance must be transmitted to OAL by 7-20-2001 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 3-22-2001 order transmitted to OAL 7-20-2001 and filed 8-31-2001 (Register 2001, No. 35).
3. Repealer and new section filed 8-10-2005; operative 9-9-2005 (Register 2005, No. 32).
4. Amendment of section heading and section filed 7-10-2019; operative 10-1-2019 (Register 2019, No. 28).

§ 1300.75.4.6. Department Costs.

The Department's costs incurred in the administration of Health and Safety Code Sections 1347.15 and 1375.4 shall come from amounts paid by plans, except specialized plans, pursuant to Health and Safety Code Section 1356.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Sections 1347.15, 1356 and 1375.4, Health and Safety Code.

HISTORY:

1. New section filed 3-22-2001 as an emergency; operative 3-22-2001 (Register 2001, No. 12). A Certificate of Compliance must be transmitted to OAL by 7-20-2001 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 3-22-2001 order transmitted to OAL 7-20-2001 and filed 8-31-2001 (Register 2001, No. 35).

§ 1300.75.4.7. Organization Evaluation.

Every contract involving a risk arrangement between a plan and an organization or a sub-delegating organization and an organization shall:

(a) Require the organization to comply with the Department of Managed Health Care's review and audit process, in determining the organization's satisfaction of the Grading Criteria; and

(b) Permit the Department to perform any of the following activities in conjunction with the plan's oversight process:

(1) Obtain and evaluate supplemental financial information pertaining to the organization when:

(A) the organization fails to satisfactorily demonstrate its compliance with the Grading Criteria;

(B) the organization experiences an event that materially alters its ability to remain compliant with the Grading Criteria;

(C) the 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) of Title 28, California Code of Regulations; or

(D) 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.

HISTORY:

1. New section filed 8-10-2005; operative 9-9-2005 (Register 2005, No. 32).
2. Amendment filed 7-10-2019; operative 10-1-2019 (Register 2019, No. 28).

§ 1300.75.4.8. Corrective Action.

Every contract involving a risk arrangement between a plan and an organization or a sub-delegating organization and an organization shall require the plan and the organization or the sub-delegating organization and the organization to comply with a process, set forth in this regulation and administered by the Department, for the development and implementation of Corrective Action Plans (CAPs).

(a) Organizations reporting deficiencies in any of the Grading Criteria shall submit a self-initiated CAP proposal on the DMHC Corrective Action Plan (CAP) Form, dated May,2018, and incorporated by reference herein, published by the Department on its webpage at www.dmhc.ca.gov to the Department and to every plan and sub-delegating organization with which the organization maintains a contract involving a risk arrangement that meets the following requirements:

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

(2) Identifies the amount by which the organization has failed to meet the Grading Criteria;

(3) Identifies all plans and sub-delegating organizations with which the organization contracts with, including the identification of the name, title, telephone and facsimile numbers, and postal and e-mail addresses for the person responsible at each contracting plan and sub-delegating organization for monitoring compliance with the final CAP;

(4) Describes 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 plans and sub-delegating organizations 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 Department;

(5) Describes the timeframe for completing the corrective action and specifies a schedule for submitting progress reports to the Department and the organization's contracting plans and sub-delegating organizations. Except in situations where the organization can demonstrate to the Department's

satisfaction and written approval that an extended period of time is necessary and appropriate to correct the deficiency, that:

(A) Timetables specified in the self-initiated CAP for correcting working capital deficiencies shall not exceed twelve (12) months;

(B) Timetables specified in the self-initiated CAP for correcting tangible net equity (TNE) deficiencies shall not exceed twelve (12) months;

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

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

(E) Timetables specified in the self-initiated CAP for correcting cash-to-claims ratio deficiencies shall not exceed twelve (12) months.

(6) Identifies 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

(7) An organization may avoid submitting a self-initiated CAP proposal if it demonstrates to the Department that necessary and prudent capital investments have caused or may cause a temporary deficiency in its TNE, working capital, or cash-to-claims ratios and that the organization has implemented an appropriate business plan that will correct the deficiency within a reasonable time period without causing a deficiency in the organization's claims processing timeliness. The organization shall seek and receive written approval from the Department to avoid submitting a self-initiated CAP proposal.

(b) To the extent possible, the self-initiated CAP proposal shall be set forth in a single document that addresses the concerns of all plans and sub-delegating organizations with which the organization maintains a contract that includes a risk arrangement.

(c) Unless, within fifteen (15) calendar days of the receipt of an organization's self-initiated CAP proposal, a contracting health plan or sub-delegating organization provides written notice to the Department and the organization stating the reason for its objections and recommendations for revisions, the self-initiated CAP shall be considered a final CAP subject to approval by the Department.

(d) In the event that a contracting plan or sub-delegating organization files a written objection with the Department and the organization, the Department shall, within ten (10) calendar days, review the objections and inform the organization if revisions to the CAP proposal are needed or if the objections can be resolved. If the objections can be resolved, the self-initiated CAP proposal shall be considered the final CAP subject to approval by the Department. If revisions to the CAP proposal are required, the organization will have ten (10) calendar days to:

(1) Implement all corrective action strategies contained in its self-initiated CAP proposal that were not objected to by a contracting plan; and

(2) Submit to each of its contracting plans and sub-delegating organizations and the Department a revised CAP proposal that addresses the concerns raised in the objections. To the extent possible, the revised CAP proposal shall be prepared as a single document that addresses the concerns of all plans and sub-delegating organizations with which the organization maintains a contract that includes a risk arrangement.

(e) Each contracting plan and sub-delegating organization shall have seven (7) calendar days to either accept or object to the self-initiated revised CAP proposal. If a plan or sub-delegating organization objects to the revised CAP proposal, the objection(s) and recommended revisions shall be submitted to the organization and the Department, in an electronic format prepared by the

Department. If there are no objections, the self-initiated revised CAP proposal shall become the final CAP subject to approval by the Department.

(f) Within seven (7) calendar days of receipt of any contracting plans' or sub-delegating organization's objections and recommended revisions to the revised CAP proposal, the Department shall schedule a meeting ("CAP Settlement Conference") with the organization and all of its contracting plans and sub-delegating organizations to discuss and reconcile the differences.

(g) Within seven (7) calendar days of the CAP Settlement Conference, the organization shall submit a final self-initiated CAP proposal to all of its contracting plans, sub-delegating organizations, and the Department.

(h) Within twenty (20) calendar days of receipt of the organization's final self-initiated CAP proposal, the external party shall submit its recommendation to the Department to approve, disapprove or modify the organization's final self-initiated CAP proposal.

(i) Within seven (7) calendar days of receipt of the external party's recommendation, the Department shall approve, disapprove or modify the organization's final self-initiated CAP proposal, which shall then become the final CAP. If the Department does not act upon the recommendations of the external party within seven (7) calendar days, the external party's recommendation shall be deemed approved.

(j) 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.

(k) In addition to the CAP requirements specified in subsection (a) above, the Department may direct an organization to initiate a CAP whenever its determines that an organization has experienced an event that materially alters its ability to remain compliant with the Grading Criteria or when the Department'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) of Title 28, California Code of Regulations.

(*l*) CAP Reporting:

(1) Each periodic progress report prepared pursuant to a final CAP shall be submitted to the Department and all plans and sub-delegating organizations 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) of 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 or sub-delegating organization and an organization shall require:

(A) the organization advise the plan and the Department in writing within five (5) calendar 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 request, provides additional documentation to the Department and its contracting plans to demonstrate the organization's progress towards fulfilling the requirements of a CAP.

(3) Non-disclosure of CAP documentation and supporting work papers:

(A) All draft, preliminary and final CAPs and all CAP compliance reports required by a final CAP, including supporting documentation and supplemental financial information, submitted to the Department shall be received and maintained on a confidential basis and shall not be disclosed, except for the

information outlined in section 1300.75.4.4(c)(3) to any party other than the organization and, as necessary, to its contracting plans and sub-delegating organizations that are participating in the CAP.

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

HISTORY:

1. New section filed 8-10-2005; operative 9-9-2005 (Register 2005, No. 32).
2. Amendment filed 7-10-2019; operative 10-1-2019 (Register 2019, No. 28).

§ 1300.76. Plan Tangible Net Equity Requirement.

(a) Except as provided in subsection (b), each plan licensed pursuant to the provisions of the Act shall, at all times, have and maintain a tangible net equity at least equal to the greater of:

(1) $1 million; or

(2) the sum of two percent (2%) of the first $150 million of annualized premium revenues plus one percent (1%) of annualized premium revenues in excess of $150 million; or

(3) an amount equal to the sum of:

(A) eight percent (8%) of the first $150 million of annualized health care expenditures except those paid on a capitated basis or managed hospital payment basis; plus

(B) four percent (4%) of the annualized health care expenditures, except those paid on a capitated basis or managed hospital payment basis, which are in excess of $150 million; plus

(C) four percent (4%) of annualized hospital expenditures paid on a managed hospital payment basis.

(b) Each plan licensed pursuant to the provisions of the Knox-Keene Act and which offers only specialized health care service contracts shall, at all times, have and maintain a tangible net equity at least equal to the greater of:

(1) $50,000; or

(2) the sum of two percent (2%) of the first $7,500,000 of annualized premium revenues plus one percent (1%) of annualized premium revenues in excess of $7,500,000; or

(3) an amount equal to the sum of:

(A) eight percent (8%) of the first $7,500,000 of annualized health care expenditures, except those paid on a capitated or managed hospital payment basis; plus

(B) four percent (4%) of the annualized health care expenditures, except those paid on a capitated basis or managed hospital payment basis, which are in excess of $7,500,000; plus

(C) four percent (4%) of annualized hospital expenditures paid on a managed hospital payment basis.

(c) For the purpose of this section "net equity" means the excess of total assets over total liabilities, excluding liabilities that have been subordinated in a manner acceptable to the Director. "Tangible net equity" means net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with nonaffiliates and which are not more than sixty (60) days past due; long term prepayments of deferred charges, and nonreturnable deposits. An obligation is fully secured for the purposes of this subsection if it is secured

by tangible collateral, other than by securities of the plan or an affiliate, with an equity of at least one-hundred and ten percent (110%) of the amount owing.

(1) Beginning October 2,2020, "positive tangible net equity" of an organization, as defined in Health and Safety Code section 1375.4(g), shall be at least equal to the greater of:

(A) one percent (1%) of annualized revenues; or

(B) four percent (4%) of annualized non-capitated medical expenses.

(2) The tangible net equity of an organization shall be determined pursuant to the criteria listed in subdivision (c) of this section.

(3) Beginning October 1,2019 and ending October 1,2020, an organization shall comply with the positive tangible net equity requirement of no less than one dollar ($1.00).

(d) For the purpose of this section, "capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.

(e) For the purpose of this section, "managed hospital payment basis" means agreements wherein the financial risk is primarily related to the degree of utilization rather than to the cost of services.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1376, Health and Safety Code.

HISTORY:

1. Amendment of subsections (b) and (c) filed 4-27-79; effective thirtieth day thereafter (Register 79, No. 17).
2. Amendment of subsection (a), new subsections (b), (c),(d), (f) and (g), renumbering of former subsection (b) and repealer of former subsection (c) filed 12-14-90; operative 12-31-91 (Register 91, No. 6).
3. Editorial correction of printing error (Register 91, No. 17).
4. Change without regulatory effect amending subsections (d)-(e) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
5. Amendment of subsection (b), repealer of subsections (c)-(d), subsection relettering and amendment of newly designated subsection (c) filed 12-9-2015; operative 4-1-2016 (Register 2015, No. 50).
6. Amendment filed 7-10-2019; operative 10-1-2019 (Register 2019, No. 28).

§ 1300.76.1. Deposits.

(a) Except as provided in subsection (b), each plan licensed pursuant to the provisions of the Act shall deposit with the Director or at the discretion of the Director with any bank authorized to do business in this state and insured by the Federal Deposit Insurance Corporation, or savings and loan association doing business in this state and insured by the Savings Association Insurance Fund, an amount which at all times shall have a value of not less than $300,000, except for plans which only offer specialized health care service contracts, which shall deposit an amount which at all times shall have a value of not less than $150,000, or plans licensed as discount health plans, which shall deposit an amount which at all times shall have a value of not less than $50,000. Cash, investment certificates, accounts, or any combination of these shall be assigned to the Director, upon those terms as the Director may prescribed, until released by the Director.

(b) Each plan licensed pursuant to the provisions of the Act prior to the effective date of this section which only offers specialized health care service contracts shall make a deposit of two-thirds of the amount required by subsection (a) within 6 months of the effective date of this section, and 100 percent of the

amount required by subsection (a) within 12 months of the effective date of this section.

(c) The deposit required by subsection (a) shall be an allowable asset of the plan in the determination of tangible net equity and all income from the deposit shall be an asset of the plan.

(d) A plan that has made a deposit pursuant to subsection (a) may withdraw that deposit or any part thereof, after making a substitute deposit of cash, investment certificates, accounts or any combination of these. Any substitute deposit shall be approved by the Director before being deposited or substituted.

(e) The deposits shall be used to protect the interests of the plan's enrollees and to assure continuation of health care services to enrollees of a plan whenever the Director has brought actions pursuant to sections 1386, 1392, 1393 or 1394.1. The Director may use the deposit for administrative costs directly attributable to a conservatorship, receivership or liquidation.

NOTE: Authority cited: Section 1344, Health & Safety Code. Reference: Section 1376, Health & Safety Code.

HISTORY:

1. New section filed 12-14-90; operative 12-31-90 (Register 91, No. 6).
2. Editorial correction of printing error (Register 91, No. 17).
3. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
4. Amendment of subsection (a), repealer of subsections (b) and (d), subsection relettering and amendment of newly designated subsection (b) filed 12-9-2015; operative 4-1-2016 (Register 2015, No. 50).

§ 1300.76.2. Solicitor Firm Financial Requirement.

(a) Each solicitor firm which handles funds of plans, subscribers, or other persons contracting with plans, shall at all times maintain a tangible net worth at least equal to 20 percent of such firm's aggregate indebtedness or $10,000, whichever is greater, and shall maintain liquid net assets of at least $5,000 in excess of it current liabilities.

(b) A solicitor firm which accepts only funds in the form of checks payable to plans, subscribers or other persons contracting with plans and forwards such checks to the payee by the close of the business day following receipt thereof does not "handle funds" within the meaning of this section.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1376, Health and Safety Code.

HISTORY:

1. Editorial correction adding NOTE filed 12-8-82 (Register 82, No. 50).

§ 1300.76.3. Fidelity Bond.

(a) Each plan shall at all times maintain a fidelity bond covering each officer, director, trustee, partner and employee of the plan, whether or not they are compensated. The fidelity bond may be either a primary commercial blanket bond or a blanket position bond written by an insurer licensed by the California Insurance Director, and it shall provide for 30 days' notice to the Director prior to cancellation. The fidelity bond shall provide at least the minimum coverage for the plan determined by the following schedule:

Annual Gross Income	Minimum Coverage
Up to $100,000	$10,000
100,000 to $300,000	20,000

Annual Gross Income	Minimum Coverage
300,000 to 500,000	30,000
500,000 to 750,000	50,000
750,000 to 1,000,000	75,000
1,000,000 to 2,000,000	100,000
2,000,000 to 4,000,000	200,000
4,000,000 to 6,000,000	400,000
6,000,000 to 10,000,000	600,000
10,000,000 to 20,000,000	1,000,000
20,000,000 and over	2,000,000

(b) The fidelity bond required pursuant to subsection (a) may contain a provision for a deductible amount from any loss which, except for such deductible provision, would be recoverable from the insurer. A deductible provision shall not be in excess of 10 percent of the required minimum bond coverage, but in no event shall the deductible amount be in excess of $100,000.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1376, Health and Safety Code.

HISTORY:
1. Editorial correction adding NOTE filed 12-8-82 (Register 82, No. 50).
2. Change without regulatory effect amending subsection (a) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.76.4. Prohibited Financial Practices.

(a) No solicitor shall maintain, and no plan or solicitor firm shall permit a solicitor in its employ to maintain, an account with a financial institution for funds of the plan, solicitor firm, subscribers or group representatives, except an account which is in the name of and under the control of the plan or solicitor firm.

(b) No solicitor shall receive funds on behalf of a plan or solicitor firm, and no plan or solicitor firm shall permit a solicitor in its employ to receive funds on behalf of the plan or solicitor firm, but this section shall not prohibit a solicitor from receiving only funds in the form of checks payable to the plan or solicitor firm if such solicitor deposits such checks to an account of the plan or solicitor firm by the close of the business day following receipt thereof or forwards such checks to the plan or solicitor firm by the close of the business day following receipt thereof.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1376, Health and Safety Code.

HISTORY:
1. New section filed 11-9-77 as an emergency; effective upon filing (Register 77, No. 46).
2. Certificate of Compliance filed 2-6-78 (Register 78, No. 6).
3. Amendment filed 12-8-82; effective thirtieth day thereafter (Register 82, No. 50).
4. Amendment of NOTE filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.77. Reimbursements.

(a) "Adequate insurance" for reimbursement for the purposes of subdivision (a)(2) of Section 1377 of the Act means a performance bond or insurance policy issued by an insurer licensed by the California Insurance Director, in an amount equal to at least the amount of cash, or cash equivalents, required to

be maintained pursuant to subdivision (a)(1) of Section 1377 of the Act. The bond or insurance policy shall be payable to a corporate trustee for the benefit of noncontracting providers, subscribers and enrollees whose claims are unpaid upon the plan ceasing to do business because of insolvency or upon the plan being adjudged bankrupt.

(b) For the purposes of subdivision (a) of Section 1377 of the Act, "equivalents" to cash include only the following, provided that the investment in any one issuer of securities (other than securities issued or fully guaranteed or insured by the United States Government or any agency thereof) does not exceed 5% of the amount required pursuant to such subdivision:

(1) Shares listed on the New York Stock Exchange, the American Stock Exchange, the Pacific Stock Exchange or the O.T.C. Margin List, which shall be valued at 90 percent of their market value.

(2) Securities issued or guaranteed by the United States Government or any agency thereof, which shall be valued at the percentages of their market value specified below:

(A) less than 3 years to maturity—100%

(B) 3 or more years to maturity—98%

(3) Obligations of any state or political subdivision or instrumentality thereof which are rated A or better by Moody's Investors Service or A or better by Standard & Poor's, which shall be valued at the percentages of their market value specified below:

(A) less than 5 years to maturity—98%

(B) 5 or more years to maturity—95%

(4) Certificates of deposit or other evidence of deposit in, or acceptance of, a bank insured by the F.D.I.C. or certificates of deposit or share accounts of a savings and loan association insured by the F.S.L.I.C., which shall be valued at their book value.

(5) Promissory notes or other evidences of indebtedness having a maturity date within nine months of issuance, exclusive of days of grace, or any renewal thereof which is likewise limited, and which are rated P2 or better by Moody's Investors Service and A2 or better by Standard & Poor's, which shall be valued at their market value.

(6) Nonconvertible debt securities having a fixed maturity which are rated A or better by Moody's Investors Service or A or better by Standard & Poor's, which shall be valued at the percentages of their market value specified below:

(A) less than 2 years to maturity—100%

(B) 2 years but less than 5 years to maturity—98%

(C) 5 or more years to maturity—95%.

(c) The Director may waive the "haircut" requirements set forth in subsection (b) subject to the condition that the plan establish and maintain a securities valuation reserve fund consisting of cash or equivalents in an amount not less than 10 percent of the total amount of "cash and equivalents" required under Section 1377 which is not otherwise maintained in cash, or such other amount as the Director may require.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1377, Health and Safety Code.

HISTORY:

1. Amendment of subsection (b) filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. New subsection (c) filed 12-8-82; effective thirtieth day thereafter (Register 82, No. 50).
3. Amendment filed 7-21-86; effective thirtieth day thereafter (Register 86, No. 30).
4. Change without regulatory effect amending subsection (c) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.77.1. Estimated Liability for Reimbursements.

A plan subject to subdivision (b) of Section 1377 shall estimate its liability for incurred and unreported claims and record such estimate as an accrual in its books and records at least monthly.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1375.1, 1376 and 1377, Health and Safety Code.

HISTORY:

1. Amendment filed 12-8-82; effective thirtieth day thereafter (Register 82, No. 50).

§ 1300.77.2. Calculation of Estimated Liability for Reimbursements.

(a) Each plan subject to subdivision (b) of Section 1377 shall calculate the estimate of incurred and unreported claims pursuant to a method held unobjectionable by the Director. Such method may include a lag study as defined and illustrated in subsection (c), an actuarial estimate as defined in subsection (d), or other reasonable method of estimating incurred and unreported claims. The amount required by Section 1300.77.1 to be accrued in the plan's books and records must equal the estimated total of all claims incurred but not yet received as of the end of the month as calculated in working papers, schedules or reports prepared in support of the unobjectionable lag study, actuarial estimate, or other method of estimating incurred and unreported claims.

(b) Working papers which support the incurred and unreported claims calculation shall be maintained as part of the records of the plan. Lag study working papers shall include a detailed allocation of all claims received each month to the various months in which the services were performed. Actuarial estimate working papers must detail all underlying assumptions and calculations in establishing the actuarial rate. Any other method used to determine the amount of incurred and unreported claims must be supported by adequate working papers, schedules or reports which detail all aspects of the incurred and unreported calculation.

(c) A "lag study" is a schedule which analyzes historical claims information on an ongoing basis to determine the length of time lag between the date of service and the date a claim is submitted to the plan for payment. Such a study distributes all claims received each month in which the services were performed. An example of a lag study containing the minimum information necessary to be held unobjectionable by the Director is as follows:

ABC HEALTH PLAN OF CALIFORNIA
SCHEDULE TO CALCULATE HISTORIC PERCENTAGE OF INCURRED BUT UNREPORTED CLAIMS FOR PRIOR MONTHLY PERIODS WHICH HAVE BEEN FULLY OR SUBSTANTIALLY REPORTED July 31, 19X2

MONTH CLAIM RECEIVED

	Same Month	*2nd*	*3rd*	*4th*	*5th*	*6th*	*7th*	*Totals for Months of Service*
Months of Service								
Oct. 19X1	$150	$500	$200	$100	$50		$1,000	
Nov. 19X1	220	500	240	110	30		1,110	
Dec. 19X1	150	600	300	100	75	$25		1,250
Jan. 19X2	210	750	375	105	60		1,500	
Feb. 19X2	230	670	290	85	100	75		1,450
Totals	$960	$3,020	$1,405	$500	$315	$100		$6,300
Percentages:								
Monthly	15%	48%	22%	8%	5%	2%		
Cumulative	15%	63%	85%	93%	98%	100%		

Explanatory notes:

1. The above represents the first schedule that is prepared to determine the incurred and unreported claims for any month following February.

2. The schedule allocates claims as they are received to the month in which the service was performed. For example, in October, the plan received $150 of claims which had service dates in October (same month). Because this schedule begins in October, the $150 amount would be the only entry which the plan would be able to make in October. In November, the plan received $220 in claims which had service dates in November (same month), and $500 of claims which had service dates in October (second month). In December, the plan received $150 of claims which had service dates in December (same month), $500 of claims which had service dates in November (second month), and $200 in claims which had service dates in October (third month).

3. The schedule indicates that $6,300 in claims were received which had service dates of October through February. Of this amount, $960 was received during the month of service (same month), $3,020 in the following (second) month, $1,405 in the third month, $500 in the fourth month, etc. By converting these amounts to percentages of the total claims, the schedule indicates that on the average, 15% ($960 ÷ $6,300 =) of all claims incurred during any month are received in the same month, 48% are received in the following (second) month, for a cumulative total of 63% (15% + 48% =) of all claims incurring during any month being received in the same and second months. By employing these cumulative percentages, the amount incurred but unreported claims can be estimated as of July 31, after the claims information for the current but incomplete monthly periods is analyzed, as illustrated in the following schedule:

ABC HEALTH PLAN OF CALIFORNIA
SCHEDULE TO ESTIMATE THE AMOUNT OF INCURRED BUT UNREPORTED CLAIMS FOR THE CURRENT BUT INCOMPLETE MONTHLY PERIODS WHICH HAVE NOT BEEN FULLY OR SUBSTANTIALLY REPORTED July 31, 19X2

MONTH CLAIM RECEIVED

	Same Month	*2nd*	*3rd*	*4th*	*5th*	*6th*	*7th*	*Totals for Months of Service*
Months of Service								
Mar., 19X2	$225	$720	$300	$120	$50			$1,415
April 19X2	250	700	330	110				1,390
May 19X2	240	750	350					1,340
June 19X2	250	775						1,025
July 19X2	270					75		270
Total Claims received for period March 1 through July 31	$5,440							

COMPUTATION OF INCURRED BUT UNREPORTED CLAIMS AS OF July 31

(A)	(B)		(C)	(D)	(E)
Month of Service	Total claims received for each month of service as of July 31		Claims received as of July 31 as a cumulative percentages of total claims to be received	Total claims to be received (B-C)	Incurred But unreported (D-B)
July	$270	(i)	15%	$1,800	$1,530
June	1,025	(ii)	63%	1,625	600
May	1,340	(iii)	85%	1,575	235
April	390	(iv)	93%	1,495	105
March	1,415	(v)	98%	1,440	25

(A)	(B)		(C)	(D)	(E)
February	1,450	(vi)	100%	1,450	0
Total incurred but unreported claims as of July 31				$2,495	

Explanatory notes:

(i) Represents July claims received in July.

(ii) Represents June claims received in June and July.

(iii) Represents May claims received in May, June and July.

(iv) Represents April claims received in April, May, June and July.

(v) Represents March claims received in March, April, May, June and July.

(vi) Represents February claims received in February, March, April, May, June and July.

(d) An "actuarial estimate" is a calculation of incurred and unreported claims which is based on adequate and reasonable assumptions with respect to risk factors and trends which have been found to be applicable to the plan, such as utilization patterns of the plan's enrollees, the average benefit which will be payable, the enrollment mix in terms of age and sex of enrollees and geographic location, actual plan contract experience, and any other factors reasonably believed to affect the amount of incurred and unreported claims. Actuarial estimates must be supported by an actuarial certification, consisting of a signed declaration of any actuary who is a member in good standing of the American Academy of Actuaries in which such actuary states that the assumptions used in calculating the incurred and unreported claims are appropriate and reasonable. If the plan employs an actuarial study to estimate the amount of the incurred and unreported claims, it must compare the actual claims amounts to those estimated, and make adjustments at least quarterly whenever a 5% difference from actual experience is noted.

(e) A plan may employ any other unobjectionable alternative method of estimating the amount of incurred and unreported claims other than the "lag study" or "actuarial estimate," so long as such alternative method accurately estimates incurred and unreported claims. For example, a plan may receive daily reports of actual hospital admissions and referrals, thereby permitting the plan to compare these reports to the actual invoices and calculate the estimated amount due hospitals for the enrollees whose claims had not been received by the plan at that time.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1375.1, 1376 and 1377, Health and Safety Code.

HISTORY:

1. New section filed 3-3-83; effective thirtieth day thereafter (Register 83, No. 10).
2. Change without regulatory effect amending subsections (a) and (c) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.77.3. Report on Reimbursements Exceeding Ten Percent.

(a) Every plan which reimburses providers of health care services or subscribers and enrollees in the manner described in subdivision (a) or (b) of Section 1377 of the Act shall make and maintain as part of its records a computation for each calendar month and calendar quarter of reimbursements

made, classified as provided in Section 1377, and showing the percentage of each class of reimbursements made to total expenditures for health care services during such month or quarter.

(b) When a report is required by subdivision (a) of Section 1377 of the Act, such report shall be filed with the Director no later than 30 business days after the close of the calendar quarter.

(c) When a report is required by subdivision (b) of Section 1377 of the Act, such report shall be filed with the Director no later than 30 business days after the close of the calendar month during which actual reimbursements made, or the amount estimated for incurred and unreported claims, exceeds 10 percent of its total expenditures for health care services.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1377, Health and Safety Code.

HISTORY:

1. Editorial correction adding NOTE filed 12-8-82 (Register 82, No. 50).
2. Change without regulatory effect amending subsections (b) and (c) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.77.4. Reimbursements on a Fee-for-Services Basis: Determination of Status of Claims.

Every plan shall institute procedures whereby all claim forms received by the plan from providers of health care services for reimbursement on a fee-for-service basis and from subscribers and enrollees for reimbursement are maintained and accounted for in a manner which permits the determination of the date of receipt of any claim, the status of any claim, the dollar amount of unpaid claims at any time, and rapid retrieval of any claim. Although any categories for status-determination held unobjectionable by the Director may be used, for the purposes of this section, the following status-determination categories, as a group, shall be presumptively reasonable:

(1) to be processed,
(2) processed, waiting for payment,
(3) pending, waiting for approval for payment or denial,
(4) pending, waiting for additional information,
(5) denied,
(6) paid, and, if appropriate,
(7) other. These procedures shall involve the use of either a claims log, claims numbering system, electronic data processing records, and/or any other method held unobjectionable by the Director.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1375.1, 1376 and 1377, Health and Safety Code.

HISTORY:

1. New section filed 3-3-83; effective thirtieth day thereafter (Register 83, No. 10).
2. Change without regulatory effect amending first paragraph and subsection (7) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.78. Administrative Costs.

(a) For the purposes of Section 1378 of the Act, "administrative costs" include only those costs which arise out of the operation of the plan as such, excluding direct and overhead costs incurred in the furnishing of health care services which would be ordinarily incurred in the provision of such services whether or not through a plan. Administrative costs include the following:

(1) Salaries, bonuses and benefits paid or incurred with respect to the officers, directors, partners, trustees or other principal management of the Plan, less to

the extent that such persons also are providers of health care services, the minimum reasonable cost of obtaining such services from others.

(2) The cost of soliciting and enrolling subscribers and enrollees, including the solicitation of group contracts, and including any indirect costs of enrollment borne on behalf of the plan by the holder of a group contract.

(3) The cost of receiving, processing and paying claims of providers of health care services and of claims for reimbursement by subscribers and enrollees, excluding the actual amount paid on such claims.

(4) Legal and accounting fees and expenses.

(5) The premium on the fidelity and surety bonds, and any insurance maintained pursuant to Section 1377, and any insurance or other expense incurred for the purposes of complying with Section 1375 of the Act. Malpractice insurance is not included within this subsection.

(6) All costs associated with the establishment and maintenance of agreements with providers of health care services, excluding the cost of reviewing quality and utilization of such services, and the cost of reviewing utilization of health care services on a referral basis.

(7) The direct or pro rata portion of all expenses incurred in the operation of the plan which are not essential to the actual provision of health care services to subscribers and enrollees, including but not limited to office supplies and equipment, clerical services, interest expense, insurance, dues and subscriptions, licenses (other than licenses for medical facilities, equipment or personnel), utilities, telephone, travel, rent, repairs and maintenance, depreciation of facilities and equipment, and charitable or other contributions.

(b) The administrative cost incurred by a plan, directly, as herein defined, shall be reasonable and necessary, taking into consideration such factors as the plan's stage of development and other considerations. If the administrative costs of an established plan exceed 15 percent, or if the administrative costs of a plan in the development phase exceed 25 percent, during any period of the revenue obtained by the plan from subscribers and enrollees, or paid to the plan on their behalf, the plan shall demonstrate to the Director, if called upon to do so, that its administrative costs are not excessive administrative costs within the meaning of Section 1378 and are justified under the circumstances and/or that it has instituted procedures to reduce administrative costs which are proving effective. An established plan is a plan which has been in operation for a period of five years or more. For the purposes of Section 1378 of the Act, money borrowed will be deemed to be money derived from revenue obtained from subscribers and enrollees to the extent that such revenue is exposed to liability for repayment of such borrowings or that repayment is anticipated from such revenues and "money not derived from" such revenues includes only net assets arising independently of the operation of the plan and not traceable on a historical basis to such revenues, whether as net profit or otherwise.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1378, Health and Safety Code.

HISTORY:

1. Editorial correction adding NOTE filed 12-8-82 (Register 82, No. 50).
2. Change without regulatory effect amending subsection (b) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

ARTICLE 10
Medical Surveys

Section
1300.80. Medical Survey Procedure.
1300.80.10. Medical Survey: Report of Correction of Deficiencies.

§ 1300.80. Medical Survey Procedure.

(a) Unless the Director in his discretion determines that advance notice will render the survey less useful, a plan will be notified approximately four weeks in advance of the date for commencement of an onsite medical survey. The Director may, without prior notice, conduct inspections of plan facilities or other elements of a medical survey, either in conjunction with the medical survey or as part of an unannounced inspection program.

(b) The onsite medical survey of a plan shall include, but not be limited to, the following procedures to the extent considered necessary based upon prior experience with the plan and in accordance with the procedures and standards developed by the Department.

(1) Review of the procedures for obtaining health services including, but not limited to, the scope of basic health care services.

(A) The availability and adequacy of facilities for telephone communication with health personnel, emergency care facilities, out-of-the-area coverage, referral procedures, and medical encounters.

(B) The means of advising enrollees of the procedures to obtain care, including the hours of operation, location and nature of facilities, types of care, telephone and other arrangements for appointment setting.

(C) The availability of qualified personnel at each facility referred to in Section 1368(b) to receive and handle inquiries concerning care, plan contracts, and grievances.

(2) Review of the design and implementation of procedures for reviewing and regulating utilization of services and facilities.

(3) Review of the design and implementation of procedures to review and control costs.

(4) Review of the design, implementation and effectiveness of the internal quality of care review systems, including review of medical records and medical records systems. A review of medical records and medical records systems may include, but is not limited to, determining whether:

(A) The entries establish the diagnosis stated, including an appropriate history and physical findings;

(B) The therapies noted reflect an awareness of current therapies;

(C) The important diagnoses are summarized or highlighted; (Important are those conditions that have a bearing on future clinical management.)

(D) Drug allergies and idiosyncratic medical problems are conspicuously noted;

(E) Pathology, laboratory and other reports are recorded;

(F) The health professional responsible for each entry is identifiable;

(G) Any necessary consultation and progress notes are evidenced as indicated;

(H) The maintenance of an appropriate system for coordination and availability of the medical records of the enrollee, including out-patient, in-patient and referral services and significant telephone consultations.

(5) Review of the overall performance of the plan in providing health care benefits, by consideration of the following:

(A) The numbers and qualifications of health professional and other personnel;

(B) The provision of, incentives for, and participation in, continuing education for health personnel and the provision for access to current medical literature;

(C) The adequacy of all physical facilities, including lighting, cleanliness, maintenance, equipment, furnishings, and convenience to enrollees, plan personnel and visitors;

(D) The practice of health professionals and allied personnel in a functionally integrated manner, including the extent of shared responsibility for patient care and coordinated use of equipment, medical records and other facilities and services;

(E) The appropriate functioning of health professionals and other health personnel, including specialists, consultants and referrals;

(F) Nursing practices, including reasonable supervision;

(G) Written nondiscriminatory personnel practices which attract and retain qualified health professionals and other personnel;

(H) The adequacy and utilization of pathology and other laboratory facilities, including the quality, efficiency and appropriateness of laboratory procedures and records and quality control procedures;

(I) X-ray and radiological services, including staffing, utilization, equipment, and the promptness of interpretation of X-ray films by a qualified physician;

(J) The handling and adequacy of medical record systems, including filing procedures, provisions for maintenance of confidentiality, the efficiency of procedures for retrieval and transmittal, and the utilization of sampling techniques for medical records audits and quality of care review;

(K) The adequacy, including convenience and readiness of availability to enrollees, of all provided services;

(L) The organization of the plan and its mechanisms for furnishing health care services, including the supervision of health professionals and other personnel;

(M) The extent to which individual medical decisions by qualified medical personnel are unduly constrained by fiscal or administrative personnel, policies or considerations;

(N) The adequacy of staffing, including medical specialties.

(6) Review of the overall performance of the plan in meeting the health needs of enrollees.

(A) Accessibility of facilities and services, based upon location of facilities, hours of operation, waiting periods for services and appointments, including elective services, the availability of parking and transportation;

(B) Continuity of care, including the ability of enrollees to select a primary care physician, staffing in medical specialties or arrangements therefor; the referral system (including instructions, monitoring and follow-up); the maintenance and ready availability of medical records; and the availability of health education to enrollees;

(C) The grievance procedure required by Section 1368 of the Act, including the availability to enrollees and subscribers of grievance procedure information, the time required for and the adequacy of the response to grievances and the utilization of grievance information by plan management.

(7) In considering the above and in pursuit of the survey objectives, the survey team may perform any or all of the following procedures:

(A) Private interviews and group conferences with enrollees, physicians and other health professionals, and members of its administrative staff including, but not limited to, its principal management persons.

(B) Examination of any records, books, reports and papers of the plan and of any management company, provider or subcontractor providing health care or other services to the plan including, but not limited to, the minutes of medical staff meetings, peer review, and quality of care review records, duty rosters of medical personnel, surgical logs, appointment records, the written procedures for the internal operation of the plan, and contracts and correspondence with enrollees and with providers of health care services and of other services to the plan, and such additional documentation the Director may specifically direct the surveyors to examine.

(C) Physical examination of facilities, including equipment.

(D) Investigation of grievances or complaints from enrollees or from the general public.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1380, Health and Safety Code.

HISTORY:

1. Amendment of subsection (b)(7)(D) filed 12-8-82; effective thirtieth day thereafter (Register 82, No. 50).
2. Change without regulatory effect amending subsections (a) and (b)(7)(B) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.80.10. Medical Survey: Report of Correction of Deficiencies.

Prior to or immediately upon the expiration of the 45-day period following notice to a plan of a deficiency as provided in subdivision (h) of Section 1380 of the Act, the plan shall file a written statement with the Director identifying the deficiency and describing the action taken to correct the deficiency and the results of such action. The report shall be signed by a principal officer of the plan.

Where such deficiencies may be reasonably adjudged to require long-term corrective action or to be of a nature which may be reasonably expected to require a period longer than 45 days to remedy, in some instances evidence that the plan has initiated remedial action and is on the way to achieving acceptable levels of compliance may be submitted.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1380, Health and Safety Code.

HISTORY:

1. Amendment filed 12-8-8; effective thirtieth day thereafter (Register 82, No. 50).
2. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
3. Amendment filed 5-7-2014; operative 7-1-2014 (Register 2014, No. 19).

ARTICLE 11
Examinations

Section

§ 1300.81. Removal of Books and Records from State.

The books and records of a plan, management company, solicitor firm, and any provider or subcontractor providing health care or other services to a plan, management company, or solicitor firm shall not be removed from this state without the prior consent of the Director.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1381, Health and Safety Code.

HISTORY:
1. Amendment filed 12-8-82; effective thirtieth day thereafter (Register 82, No. 50).
2. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.82. Examination Procedure.

Regular and additional or nonroutine examinations conducted by the Department pursuant to Section 1382 will ordinarily be commenced on an unannounced basis. To the extent feasible, deficiencies noted will be called to the attention of the responsible officers of the company under examination during the course of the examination, and in that event the company should take the corrective action indicated. When deemed appropriate, the company will be advised by letter of the deficiencies noted upon the examination. If the deficiency letter requires a report from the company, such report must be furnished within 15 days or such additional time as may be allowed.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1382, Health and Safety Code.

HISTORY:
1. Amendment filed 12-8-82; effective thirtieth day thereafter (Register 82, No. 50).

§ 1300.82.1. Additional or Nonroutine Examinations and Surveys.

(a) An examination or survey is additional or nonroutine for good cause for the purposes of Section 1382(b) when the reason for such examination or survey is any of the following:

(1) The plan's noncompliance with written instructions from the Department;

(2) The plan has violated, or the Director has reason to believe that the plan has violated, any of the provisions of Sections 1352, 1370, 1371, 1371.35, 1371.37, 1375.1, 1376, 1384 and 1385 of the Act and Sections 1300.71, 1300.71.38, 1300.76, 1300.80.10, 1300.81, 1300.82(a), 1300.84.2 and 1300.84.3 of these regulations.

(3) The plan has committed, or the Director has reason to believe that the plan has committed, any of the acts or omissions enumerated in Section 1386 of the Act.

(4) The Director deems such additional or nonroutine examination or survey necessary to verify representations made to this Department by a plan in response to a deficiency letter.

(b) Each situation giving rise to an additional or nonroutine examination or survey shall be evaluated on a case-by-case basis as to the seriousness of the violation, or lack of timely or adequate response by the plan to the Department's request to correct the violation. The plan shall be notified in writing of the provisions of the Act or regulations which have been, or may have been, violated and which therefore caused such additional or nonroutine examination or survey to be performed. The expense of such examinations and surveys shall be charged to the plan being examined or surveyed in accordance with Section 1382(b).

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1352, 1370, 1375.1, 1376, 1380, 1382, 1384, 1385 and 1386, Health and Safety Code.

HISTORY:
1. New section filed 3-3-83; effective thirtieth day thereafter (Register 83, No. 10).
2. Change without regulatory effect amending subsections (a)(2)-(4) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
3. Amendment of subsection (a)(2) filed 12-9-2015; operative 4-1-2016 (Register 2015, No. 50).

ARTICLE 12
Reports

Section

§ 1300.83. Annual Report. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Stats. 1979, Ch. 1083.

HISTORY:
1. Repealer filed 5-9-80; effective thirtieth day thereafter (Register 80, No. 19).

§ 1300.84. Financial Statements.

(a) Whenever pursuant to these rules or pursuant to an order or request of the Director pursuant to the Act a financial statement or other report is required to be audited or be accompanied by the opinion of a certified public accountant or public accountant, such accountant shall be independent of the licensee, determined in accordance with section 602.02 of Financial Reporting Release Number 1 issued by the Securities and Exchange Commission.

(b) The financial statements required under subsections (a), (b) and (c) of Section 1384 of the Act shall be audited by an independent accountant in accordance with section 1300.45(e).

(c) Except as provided in subsection (d), financial statements of a plan required pursuant to these rules must be on a combining basis with an affiliate, if the plan or such affiliate is substantially dependent upon the other for the provision of health care, management or other services. An affiliate will normally be required to be combined, regardless of its form of organization, if the following conditions exist:

(1) The affiliate controls, is controlled by, or is under common control with, the plan, either directly or indirectly (see subsections (c) and (d) of section 1300.45), and

(2) The plan or the affiliate is substantially dependent, either directly or indirectly, upon the other for services or revenue.

(d) Upon written request of a plan, the Director may waive the requirement that an affiliate be combined in financial statements required pursuant to these rules. Normally, a waiver will be granted only when

(1) the affiliate is not directly engaged in the delivery of health care services or

(2) the affiliate is operating under an authority granted by a governmental agency pursuant to which the affiliate is required to submit periodic financial reports in a form prescribed by such governmental agency that cannot practicably be reformatted into the form prescribed by these rules (such as an insurance company).

(e) When combined financial statements are required by this section, the independent accountant's report or opinion must cover all the entities included in the combined financial statements. If the accountant's report or opinion makes reference to the fact that a part of the examination was performed by another auditor, the plan shall also file the individual financial statements and report or opinion issued by the other auditor.

(f) Plans which have subsidiaries that are required to be consolidated under generally accepted accounting principles must present either

(1) consolidating financial statements, or

(2) consolidating schedules for the balance sheet and statement of operations, which in either case must show the plan separate from the other entities included in the consolidated balances.

(g) This section shall not apply to a plan which is a public entity or political subdivision.

(h) All filings of financial statements required pursuant to these rules must include an original and one copy.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1384, Health and Safety Code.

HISTORY:

1. Amendment filed 5-9-80; effective thirtieth day thereafter (Register 80, No. 19).
2. Amendment filed 7-3-84; effective thirtieth day thereafter (Register 84, No. 27).
3. Amendment of subsection (e) and new subsection (h) filed 7-21-86; effective thirtieth day thereafter (Register 86, No. 30).
4. Amendment of subsection (a) filed 12-14-90; operative 12-31-90 (Register 91, No. 6).
5. Change without regulatory effect amending subsections (a) and (d) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.84.03. Required Notice to the Department.

(a) Each plan shall maintain internal procedures that provide one or more of its principal officers on at least a monthly basis with the information necessary for the reports required pursuant to Rule 1300.84.3.

(b)(1) Each plan shall notify the Department if, based on a review of its financial and business records, it determines that currently or within 30 business days the plan will:

(A) Be unable to meet its obligations as they become due; or

(B) Have tangible net equity below the amount required by subdivisions (a) or (b) of Rule 1300.76, as applicable.

(2) The notification by the plan to the Department shall be made in writing within 5 business days of any determination made pursuant to subsection (b) of this Rule.

NOTE: Authority cited: Sections 1344, 1348.95 and 1384, Health and Safety Code. Reference: Sections 1348.95 and 1384, Health and Safety Code.

HISTORY:

1. New section filed 5–18–2022; operative 7–1–2022 (Register 2022, No. 20).

§ 1300.84.05. Change of Independent Accountant.

Whenever the financial statements required pursuant to subdivisions (a), (b) or (c) of Section 1384 are to be reported upon or certified by an accountant

other than the accountant certifying the plan's most recent filing, the plan must furnish the Director with a separate letter stating whether in the eighteen (18) months preceding the engagement of the new accountants there was any disagreement with the former accountants on any matter of accounting principles or practices, financial statement disclosure or auditing procedures, which such disagreement if not resolved to the satisfaction of the former accountants would have caused him to make reference to the subject matter of such disagreement in his opinion or report. This letter must be verified by a principal officer of the plan. The plan shall also request the former accountants to furnish them with a letter addressed to the Director stating whether he agrees with the statements contained in the letter of the plan and, if not, stating the respects in which he does not agree. The notification by the plan along with the former accountant's letter, if necessary, must be furnished to the Director within 45 days of the engagement of the new accountants.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1345 and 1384, Health and Safety Code.

HISTORY:

1. New section filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. Change without regulatory effect amending section filed 7-14-99 pursuant to section 100, title 1, California Code of Regulations (Register 99, No. 29).
3. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.84.06. Plan Annual Report. [Renumbered]

NOTE: Authority cited: Sections 1344 and 1384, Health and Safety Code. Reference: Section 1384, Health and Safety Code.

HISTORY:

1. New section filed 5–9–80; effective thirtieth day thereafter (Register 80, No. 19).
2. Amendment filed 7–21–86; effective thirtieth day thereafter (Register 86, No. 30).
3. Amendment filed 12–14–90; operative 12–31–90 (Register 91, No. 6).
4. Repealer and new subsection (a) filed 12–9–2015; operative 4–1–2016 (Register 2015, No. 50).
5. Renumbering of former section 1300.84.06 to section 1300.84.1 filed 5–18–2022; operative 7–1–2022 (Register 2022, No. 20).

§ 1300.84.1. Plan Annual Report.

(a) Each plan shall submit the "Annual DMHC Financial Reporting Form," hereinafter "Annual Report," (Form No. 10–072) dated [July 1, 2022], as incorporated herein by reference, and published by the Department on its website: www.dmhc.ca.gov, within 120 days after the close of the fiscal year, or as otherwise required by Health and Safety Code section 1384.

(b) The Annual Report shall be submitted to the Department in the manner described in the "Annual, Quarterly, and Monthly Financial Reporting Forms Instruction Manual," hereinafter "Annual, Quarterly, and Monthly Financial Reporting Forms Instruction Manual," dated [July 1, 2022], as incorporated herein by reference, and published by the Department on its website: www.dmhc.ca.gov.

(c) The Annual Report shall be considered the plan's annual financial statement report for purposes of Health and Safety Code section 1384 and shall include all the requested information prescribed in both the Annual Report and the Annual, Quarterly, and Monthly Financial Reporting Forms Instruction Manual. The information provided by the plan in the Annual Report shall cover the applicable time period specified in the Annual, Quarterly, and Monthly Financial Reporting Forms Instruction Manual.

NOTE: Authority cited: Sections 1344, 1348.95 and 1384, Health and Safety Code. Reference: Sections 1348.95 and 1384, Health and Safety Code.

HISTORY:
1. Renumbering of former section 1300.84.06 to section 1300.84.1 filed 5–18–2022; operative 7–1–2022 (Register 2022, No. 20). For prior history of section 1300.84.1, see Register 86, No. 30.

§ 1300.84.2. Quarterly Financial Reports.

(a) Each plan shall submit the "Quarterly DMHC Financial Reporting Form", hereinafter "Quarterly Report" (Form No. 10–071), dated [July 1, 2022], as incorporated herein by reference, and published by the Department on its website: www.dmhc.ca.gov, within 45 days after the close of each quarter of its fiscal year.

(b) The Quarterly Report shall include all of the requested information prescribed in both the Quarterly Report and the Annual, Quarterly, and Monthly Financial Reporting Forms Instruction Manual, as incorporated by reference in Rule 1300.84.1.

(c) The Quarterly Report shall be submitted to the Department in the manner described in, and shall cover the applicable time period specified in, the Annual, Quarterly, and Monthly Financial Reporting Forms Instruction Manual, as incorporated by reference in Rule 1300.84.1.

NOTE: Authority cited: Sections 1344, 1348.95 and 1384, Health and Safety Code. Reference: Sections 1348.95 and 1384, Health and Safety Code.

HISTORY:
1. Amendment filed 5–9–80; effective thirtieth day thereafter (Register 80, No. 19).
2. Amendment filed 7–21–86; effective thirtieth day thereafter (Register 86, No. 30).
3. Change without regulatory effect amending first paragraph and subsection (a) filed 7–18–2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
4. Amendment of subsection (a) filed 12–9–2015; operative 4–1–2016 (Register 2015, No. 50).
5. Repealer and new section and amendment of NOTE filed 5–18–2022; operative 7–1–2022 (Register 2022, No. 20).

§ 1300.84.3. Monthly Financial Reports.

(a) Each plan that has not been licensed by the Department and operated as a health care service plan for twelve (12) consecutive calendar months shall file with the Department the "Monthly DMHC Financial Reporting Form," hereinafter "Monthly Report" (Form No. 10–070), dated [July 1, 2022], as incorporated herein by reference, and published by the Department on its website: www.dmhc.ca.gov, within 30 calendar days after the last day of the month.

(b) Each plan shall file the Monthly Report with the Department within 30 calendar days after the last day of any month during which its:

(1) Tangible net equity, individually or on a combined basis with affiliates, is less than 150%, or less than 130% for a point–of–service contract, of the minimum tangible net equity required by subdivisions (a) or (b) of Rule 1300.76, as applicable; or

(2) Report # 2 within the Monthly Report, individually or on a combined basis with affiliates, reflects a loss for the month the amount of which exceeds the difference between the tangible net equity of the plan (or the combined entity) as of the end of such month and the minimum net equity required by subdivisions (a) or (b) of Rule 1300.76, as applicable.

(c) A plan shall continue to file the Monthly Report required by subdivisions (a) or (b) of this Rule each month until it demonstrates and is notified by the Department that the plan has met all of the following conditions:

(1) The plan's tangible net equity, individually or on a combined basis with affiliates, has been 150% or more, or 130% or more for a point–of–service contract, of the minimum tangible net equity required by subdivisions (a) or (b) of Rule 1300.76, as applicable, for six consecutive calendar months;

(2) The plan has met the requirements of subdivision (a) of Rule 1300.75.1, as demonstrated in the plan's Monthly Report filing for six consecutive calendar months; and

(3) The plan has been licensed and operated as a health care service plan for at least twelve consecutive calendar months.

(d) The Monthly Report shall include all the requested information prescribed in both the Monthly Report and the Annual, Quarterly, and Monthly Financial Reporting Forms Instruction Manual, as incorporated by reference in Rule 1300.84.1. The Monthly Report shall be submitted to the Department in the manner described in, and shall cover the applicable time period specified in, the Annual, Quarterly, and Monthly Financial Reporting Forms Instruction Manual, as incorporated by reference in Rule 1300.84.1.

NOTE: Authority cited: Sections 1344, 1348.95 and 1384, Health and Safety Code. Reference: Sections 1348.95 and 1384, Health and Safety Code.

HISTORY:

1. Amendment of subsection (d) filed 6–2–78; effective thirtieth day thereafter (Register 78, No. 22).
2. Amendment of subsection (d) filed 7–3–84; effective thirtieth day thereafter (Register 84, No. 27).
3. Amendment filed 7–21–86; effective thirtieth day thereafter (Register 86, No. 30).
4. Change without regulatory effect of subsection (d) (Register 86, No. 38).
5. Amendment of subsection (d) filed 12–14–90; operative 12–31–90 (Register 91, No. 6).
6. Change without regulatory effect amending subsection (e) filed 4–4–2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 14).
7. Change without regulatory effect amending subsections (b), (c) and (d) filed 7–18–2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
8. Amendment of subsection (d)(1) and repealer of subsections (d)(1)(A)–(G) filed 12–9–2015; operative 4–1–2016 (Register 2015, No. 50).
9. Repealer and new section and amendment of NOTE filed 5–18–2022; operative 7–1–2022 (Register 2022, No. 20)

§ 1300.84.4. Financial Reports by Solicitor Firms. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1384, Health and Safety Code.

HISTORY:

1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
2. Repealer filed 7-3-84; effective thirtieth day thereafter (Register 84, No. 27).

§ 1300.84.5. Public Entity Plans.

(a) A plan which is a public entity or political subdivision shall be subject to the provisions of this section.

(1) Financial statements of a plan which is a public entity or political subdivision, including financial statements or reports of specific funds or groups of accounts where health plan activity is recorded, which are required to be submitted pursuant to Section 1351(h) or 1384(c) of the Act or by rule, order or request of the Director, shall be accompanied either by an opinion of a certified public accountant or public accountant or by a report of a government audit organization.

(2) For the purposes of Sections 1351 and 1384, governmental auditing standards are defined to include the standards set forth in this item. Every audit which results in the opinion or report referred to in Item (1) of this

subsection shall be conducted in accordance with the governmental auditing standards indicated below:

(A) General Standards:

(i) The auditors assigned to perform the audit must collectively possess adequate professional proficiency for the tasks required.

(ii) In all matters relating to the audit work, the audit organization and the individual auditors, whether government or public, must be free from personal or external impairments to independence, must be organizationally independent, and shall maintain an independent attitude and appearance.

(iii) Due professional care is to be used in conducting the audit and in preparing related reports.

(B) Standards of Field Work:

(i) The work is to be adequately planned and assistants, if any, are to be properly supervised.

(ii) There is to be a proper study and evaluation of the existing internal control as a basis for reliance thereon and for the determination of the resultant extent of the tests to which auditing procedures are to be restricted.

(iii) Sufficient competent evidential matter is to be obtained through inspection, observation, inquiries, and confirmations to afford a reasonable basis for an opinion regarding the financial statements under examination.

(C) Standards of Reporting:

(i) The report shall state whether the financial statements are presented in accordance with generally accepted accounting principles.

(ii) The report shall state whether such principles have been consistently observed in the current period in relation to the preceding period.

(iii) Informative disclosures in the financial statement are to be regarded as reasonably adequate unless otherwise stated in the report.

(iv) The report shall either contain an expression of opinion regarding the financial statements, taken as a whole, or an assertion to the effect that an opinion cannot be expressed. When an overall opinion cannot be expressed, the reasons therefor should be stated. In all cases where an auditor's name is associated with financial statements, the report should contain a clear-cut indication of the character of the auditor's examination, if any, and the degree of responsibility he is taking.

(D) Additional Standards and Requirements on Examination and Evaluation for Government Financial and Compliance Audits.

(i) Planning shall include consideration of the requirements of all levels of government.

(ii) A review is to be made of compliance with applicable laws and regulations.

(iii) A written record of the auditors' work shall be retained in the form of working papers.

(iv) Auditors shall be alert to situations or transactions that could be indicative of fraud, abuse, and illegal expenditures and acts and if such evidence exists, extend audit steps and procedures to identify the effect on the entity's financial statements.

(E) Additional Standards and Requirements on Reporting for Government Financial and Compliance Audits.

(i) Written audit reports are to be submitted to the appropriate officials of the organization audited and to the appropriate officials of the organizations requiring or arranging for the audits unless legal restrictions or ethical considerations prevent it. Copies of the reports should also be sent to other officials who may be responsible for taking action and to others authorized to receive such reports. Unless restricted by law or regulations, copies should be made available for public inspection.

(ii) A statement in the auditors' report that the examination was made in accordance with generally accepted government auditing standards for financial and compliance audits will be acceptable language to indicate that the audit was made in accordance with these standards.

(iii) Either the auditors' report on the entity's financial statements or a separate report shall contain a statement of positive assurance on those items of compliance tested and negative assurance on those items not tested. It shall also include material instances of noncompliance and instances or indications of fraud, abuse, or illegal acts found during or in connection with the audit.

(iv) The auditors shall report on their study and evaluation of internal accounting controls made as part of the financial and compliance audit. They shall identify as a minimum: (a) the entity's significant internal accounting controls, (b) the controls identified that were evaluated, (c) the controls identified that were not evaluated (the auditor may satisfy this requirement by identifying any significant classes of transactions and related assets not included in the study and evaluation), and (d) the material weaknesses identified as a result of the evaluation.

(v) Either the auditors' report on the entity's financial statements or a separate report shall contain any other material deficiency findings identified during the audit not covered in (ii) above.

(vi) If certain information is prohibited from general disclosure, the report shall state the nature of the information omitted and the requirement that makes the omission necessary.

(3) Financial statements, including reports of specific funds or groups of accounts, which are to be submitted pursuant to this section must be previously approved as to form by the Director. When all health plan activity has been separately controlled and accounted for in an Enterprise Fund, the financial statements or reports of such funds are presumptively approved as to form for purposes of this subsection.

(b) A plan which is a public entity or political subdivision shall be granted a total or partial exemption from Sections 1300.84.06 and 1300.84.2 upon proper application therefor, when and to the extent that

(1) the Director determines that such plan has demonstrated that the information set forth in Sections 1300.84.06 and 1300.84.2 is neither available to the plan nor necessary for its internal management and cannot be produced without significant cost to the plan, and

(2) such plan undertakes to furnish alternative information which the Director finds to be reasonable and adequate in view of the circumstances of the plan.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1345, 1351, 1384 and 1385, Health and Safety Code.

HISTORY:

1. New section filed 5-9-80; effective thirtieth day thereafter (Register 80, No. 19).
2. Amendment filed 7-3-84; effective thirtieth day thereafter (Register 84, No. 27).
3. Change without regulatory effect amending subsections (a)(1), (a)(3) and (b)(1)-(2) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.84.6. Plan Annual Enrollee Report.

(a) On or before May 15th of each year, each licensed plan shall file a report in the following form and containing the information specified therein:

State of California Dept. of Managed Care

Department of Managed Care File Number _____

REPORT OF ENROLLMENT IN PLAN
Knox-Keene Health Care Service Plan Act

1. Name of Plan:

2. Name, mailing address, and telephone number of Plan official to whom communications concerning this report should be addressed:

_____ ( )_____
Name Phone No.—Include area code

_____
Mailing Address

_____
City, State and ZIP Code

3. For the purposes of Section 1356(b) of the Knox-Keene Health Care Service Plan Act, the Plan reports that, as of March 31 of the year in which this report is made, its records reflected the following enrollments, in accordance with the definitions contained in Section 1345, Health and Safety Code:

Number of subscribers _____

Number of enrollees _____

(NOTE: As required by Section 1356(b), if the number of enrollees is estimated, the method used for determining the estimated enrollment must be disclosed.)

4. Execution: I certify under penalty of perjury that the above statement is true.

Executed at _____ on _____
City and State Date

_____
Signature

_____
Print or Type Name of Declarant

_____
Position with Plan

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1356, 1384 and 1385, Health and Safety Code.

HISTORY:
1. New section filed 5-9-80; effective thirtieth day thereafter (Register 80, No. 19).
2. Change without regulatory effect amending section filed 1-23-91 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 10).
3. Change without regulatory effect amending subsection (a) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.84.7. Special Reports Relating to Charitable or Public Activities.

(a) Any plan whose purposes involve any charitable or public purposes shall provide a special report to the Director upon filing with the Attorney General any notice, request, or other materials pursuant to any law administered by the Attorney General and relating to matters which will or may have any financial effect on or implications for the plan. Such special report shall include the information provided to the Attorney General together with representations as to whether the transactions, actions, or other facts set forth in the materials submitted to the Attorney General will or may have any deleterious effect on the financial condition of the plan.

(b) Any plan whose purposes involved any charitable or public purposes shall provide a special report to the Director upon engaging in any transaction to which the corporation is a party and in which one or more of its directors has a material financial interest, if such transaction will or may have any material financial effect on or implications for the plan. Such special report shall specifically describe the transaction and shall contain representations as to whether the transaction will or may have any deleterious effect on the financial condition or operations of the plan.

(c) Any filing pursuant to this section may be combined with any appropriate filings pursuant to Article 2, Part 11, Division 2, Title 1 of the Corporations Code and may utilize common exhibits, subject to the provisions of Section 1300.824(c).

NOTE: Authority cited: Section 1344, Health and Safety Code, Reference: Section 1384, Health and Safety Code.

HISTORY:

1. New section filed 4-16-82; effective thirtieth day thereafter (Register 82, No. 16).
2. Change without regulatory effect amending subsections (a) and (b) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

ARTICLE 13
Books and Records

Section

§ 1300.85. Books and Records.

(a) Each plan, solicitor firm, and solicitor shall keep and maintain their books of account and other records on a current basis.

(b) Each plan shall make or cause to be made and retain books and records which accurately reflect:

(1) The names and last known addresses of all subscribers to the plan.

(2) All contracts required to be submitted to the Department and all other contracts entered into by the plan.

(3) All requests made to the plan for payment of moneys for health care services, the date of such requests, and the dispositions thereof.

(4) A current list of the names and addresses of all individuals employed by it as a solicitor.

(5) A current list of the names and addresses of all solicitor firms with which it contracts.

(6) A current list of the names and addresses of all of the plan's officers, directors, principal shareholders, general managers, and other principal persons.

(7) The amount of any commissions paid to persons who obtain members for plans and the manner in which said commissions are determined.

(c) Each solicitor firm shall make and retain books and records which include a current list of the names and addresses of its partners, if any, and all of its employees who make act as solicitors.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1385, Health and Safety Code.

HISTORY:

1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.85.1. Retention of Books and Records.

Every plan and solicitor firm shall preserve for a period of not less than five years, the last two years of which shall be in an easily accessible place at the offices of the plan or solicitor firm, the books of account and other records required under the provisions of, and for the purpose of the Act. After such books and records have been preserved for two years, they may be warehoused or stored, or microfilmed, subject to their availability to the Director within not more than 5 days after request therefore.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1385, Health and Safety Code.

HISTORY:

1. Change without regulatory effect amending section and adding Note filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

ARTICLE 14
Miscellaneous Provisions

Section

§ 1300.86. Assessment of Administrative Penalties.

(a) When assessing administrative penalties against a health plan the Director shall determine the appropriate amount of the penalty for each violation of the Act based upon one or more of the factors set forth in subsection (b).

(b) The factors referred to in subsection (a) include, but are not limited to the following:

(1) The nature, scope, and gravity of the violation;

(2) The good or bad faith of the plan;

(3) The plan's history of violations;

(4) The willfulness of the violation;

(5) The nature and extent to which the plan cooperated with the Department's investigation;

(6) The nature and extent to which the plan aggravated or mitigated any injury or damage caused by the violation;

(7) The nature and extent to which the plan has taken corrective action to ensure the violation will not recur;

(8) The financial status of the plan;

(9) The financial cost of the health care service that was denied, delayed, or modified;

(10) Whether the violation is an isolated incident; and/or

(11) The amount of the penalty necessary to deter similar violations in the future.

NOTE: Authority cited: Sections 1341, 1344 and 1386, Health and Safety Code. Reference: Section 1386, Health and Safety Code.

HISTORY:

1. New section filed 11-8-2004; operative 12-8-2004 (Register 2004, No. 46).

§ 1300.87. Civil Penalties.

For purposes of section 1387 of the Health and Safety Code:

(a) A violation that is ongoing and continuous is subject to a civil penalty not to exceed two thousand five hundred dollars ($2,500) for each day that the violation continues.

(b) Each enrollee harmed by a violation of the Act constitutes a separate and distinct violation subject to a civil penalty not to exceed two thousand five hundred dollars ($2,500).

NOTE: Authority cited: Sections 1344 and 1387, Health and Safety Code. Reference: Section 1387, Health and Safety Code; and Section 11425.50, Government Code.

HISTORY:

1. New section filed 9-18-2003; operative 9-18-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 38).

§ 1300.89. Petition for Restoration.

(a) The fee for the filing of a petition for restoration shall be $100 for a solicitor, $250 for a solicitor firm, and $500 for a plan.

(b) A petition for restoration shall be made upon the following form:

(Official Use Only)	DEPARTMENT OF MANAGED CARE File No. _____ (Insert file number of previous filings before the Department, if any.)
Fee Paid $_____	FILING FEE: Solicitor: $100 Solicitor firm: $250 Plan: $500
Receipt No. _____	Not refundable except pursuant to Section 250.15, Title 10, California Code of Regulations.

EXECUTION PAGE

DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

PETITION FOR RESTORATION
UNDER THE
KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975

INDICATE TYPE OF FILING BY CHECKING ONE OF THE FOLLOWING:
[ ] ORIGINAL PETITION FOR SOLICITOR
[ ] ORIGINAL PETITION FOR SOLICITOR FIRM
[ ] ORIGINAL PETITION FOR PLAN
[ ] AMENDMENT TO PETITION FOR SOLICITOR
[ ] AMENDMENT TO PETITION FOR SOLICITOR FIRM
[ ] AMENDMENT TO PETITION FOR PLAN
[ ] SUBSEQUENT PETITION
Date first petitioned for restoration _____
Date of any subsequent petitions _____

1. Name of petitioner (Complete name as appearing on articles of incorporation, partnership agreement, etc.)

_____

2. Address of principle office of petitioner.
(Number and Street) (City) (State) (Zip Code)

_____

3. Address of principle office of petitioner in the State of California.
(Number and Street) (City) (State) (Zip Code)

_____

4. Name and address of person to whom communications should be addressed concerning this petition.

_____

5. Within 20 days of a request from the Director, the petitioner shall furnish additional information as the Director may require pursuant to subsection (c) of this section.

_____

EXECUTION

The undersigned, duly authorized by the petitioner, has signed this petition on the petitioner's behalf.

_____ By:_____
(Petitioner) Title: _____

I certify under penalty of perjury that I have read this petition and the exhibits and attachments and know the contents, and that the statements are true.

Executed at _____ on _____, _____
(City) (State)

_____
(Signature of Declarant)

(If executed other than in a state which permits verifications under penalty of perjury, attach a verification executed and sworn to before a Notary Public.)

---

6. Name and address of officer or partner of petitioner who is to receive compliance and informational communications from the Department and who is responsible for disseminating the same within the petitioner's organization.

7. Set forth the grounds upon which the license, employment, or activity was suspended, revoked, or barred. Attach a copy of the decision, administrative record, and order suspending, revoking or barring petitioner.

8. Set forth the basis upon which petitioner believes that restoration is warranted.

9. Set forth the steps which petitioner has taken to prevent a recurrence of the grounds referred to in item 7, above, and any other information which petitioner believes to be relevant.

10. If the petitioner is a plan, is its application on file with the Department current without the need for any amendment?

[ ] Yes [ ] No

If "no," state the day on which petitioner will comply with subsection (c) of this section.

11. If the petitioner is a plan, attach as exhibits all current reports, information, and statements which are required to be filed under the Act or rules but which have not been filed to date.

12. If the petitioner is a solicitor firm, describe the organization of petitioner, identify its principal persons, and describe the manner in which it proposes to act as a solicitor firm.

13. If the petitioner is a solicitor firm, attach financial statements as required:

A. If petitioner is subject to the tangible net worth requirement of Section 1300.76.2, Title 28, Calif. Code of Regulations, attach a copy of petitioner's financial statement consisting of at least a balance sheet and statement reporting the results of operations for the petitioner, prepared as of a date within 30 days of the filing of this petition. Such financial statement need not be certified, but if not certified, also attach as an exhibit certified financial statements of the petitioner as of the close of its last fiscal year.

B. If petitioner is exempted from Section 1300.76.2, attach a statement to that effect and attach a copy of petitioner's financial statement, which need not be certified, consisting of at least a balance sheet and statement reporting the

results of operations for the petitioner, prepared as of a date within 30 days of the filing of this petition.

C. If petitioner accepts no funds, in the form of; checks or otherwise, of plans, subscribers or other persons contracting with plans (exclusive of petitioner's compensation for its solicitation activities), attach a statement to that effect, and do not include financial statements of the petitioner as an exhibit to the petition.

14. If petitioner has applied for restoration previously and been denied, attach copies of all prior petitions, administrative records, and decisions on those petitions.

(c) If the petition provided in subsection (b) is filed by a plan, the plan shall file an amendment to its application on file with the Department which will bring that application current, or, if its application is current without the need for any amendment, it shall so allege.

(d) The Director may require additional information and/or undertakings as a condition of granting a petition for restoration. This requested material will be used to determine whether the petitioner, if restored, would engage in business in full compliance with the objectives and provisions of the Act and the applicable regulations. The Director, in evaluating the rehabilitation of the petitioner and his or her eligibility for a license or status as a solicitor, shall consider the following criteria:

(1) The nature and severity of the act(s) or offense(s).

(2) The administrative record applicable to the disciplinary proceedings.

(3) The time that has elapsed since commission of the act(s) or offense(s).

(4) Whether the petitioner has complied with any terms of parole, probation, restitution or any other sanctions imposed against him or her.

(5) If applicable, evidence of expungement proceedings pursuant to Section 1203.4 of the Penal Code.

(6) Evidence, if any, of rehabilitation submitted by the petitioner.

(7) Any other information; or material that the Director deems to be appropriate and relevant.

NOTE: Authority cited; Section 1344, Health and Safety Code. Reference: Section 1389, Health and Safety Code.

HISTORY:

1. New section filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
2. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
3. Change without regulatory effect updating title reference on sample execution page filed 12-22-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 51).
4. Change without regulatory effect amending subsection (b) filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).
5. Amendment filed 12-16-2002; operative 1-15-2003 (Register 2002, No. 51).

§ 1300.89.21. Rescissions.

(a) Definitions

(1) Rescission or rescind means a cancellation of coverage for fraud or intentional misrepresentation of material fact that has a retroactive effect. A cancellation of coverage with only a prospective effect is not a rescission.

(2) "Effective date of the rescission" in section 1389.21 subdivision (b) of the Health and Safety Code means the date on which the plan retroactively cancels coverage based on fraud or intentional misrepresentation of material fact.

(b) General Requirements

(1) The health plan must provide the enrollee or subscriber with written notice of intent to rescind containing elements required under Health and Safety Code section 1389.21, as well as any and all requirements described in section 1300.65, of this title.

(2) If the enrollee or subscriber requests review of the rescission pursuant to Health and Safety Code section 1365, subdivision (b), the plan must continue or reinstate coverage as required by that section and section 1300.65 of this title.

(c) Enforcement

The failure of a plan to comply with the requirements of section 1389.21 and 1365 of the Act and this regulation may constitute a basis for disciplinary action against the plan. The Director shall have the civil, criminal, and administrative remedies available under the Act, including Health and Safety Code section 1394.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1365 and 1389.21, Health and Safety Code.

HISTORY:

1. New section filed 12-22-2014; operative 1-1-2015 pursuant to Government Code section 11343.4(b)(3) (Register 2014, No. 52).

§ 1300.99. Application to Surrender License.

An application to surrender a license as a health plan shall be filed with the Director, in the following form:

DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

APPLICATION FOR SURRENDER OF LICENSE
PURSUANT TO
SECTION 1399, HEALTH AND SAFETY CODE

Date of Application _____

Dept. of Managed Care File No. _____

1. Name of Licensee (as appearing in license)

_____

2. Person to be contacted regarding this application.

Name _____

Address _____

_____

Telephone Number _____

3. Reason for Surrender of License (explain briefly):

4. Date upon which licensee proposes to terminate business:

_____

If the date is subject to contingencies or will be determined hereafter, explain briefly below:

5. Complete the following:

a. Attach a copy of the balance sheet and a statement of income and expense for the plan, prepared as of a date within 30 days of the filing of this application. Such financial statements need not be certified.

b. State whether the licensee is required to file certain reports pursuant to Section 1384 of the Knox-Keene Health Care Service Plan Act of 1975.

If so, state the date by which the licensee will forward such reports to the Director:

_____

c. Section 1300.85.1. of the rules pursuant to the Knox-Keene Health Care Service Plan Act of 1975 requires that the books and records of a plan be preserved for a period of five years. State the name and address of the custodian of the plan's books and records and the address at which such records will be located:

Custodian: ._____

_____

Location: _____

_____

d. Describe in an attachment hereto the licensee's plans for the termination of its business as a health care service plan or specialized health care service plan, including the following information:

1. The provision for payment of any amounts due to subscribers and enrollees and the aggregate amount owed thereto.

2. The provision for payment of any amounts due to providers of health care services, the aggregate owed thereto and a schedule showing the persons to whom such amounts are owed, the amount due each such person, and the date such liability first became due and payable.

3. The final date for payment of periodic payments by or on behalf of subscribers for health care services, and the final date which the plan will be obligated to furnish health care services by reason of such payments.

4. If an insurer assumes obligations as to the plans subscribers and enrollees, attach a detailed statement of the plan for the assumption of business by the subsequent provider or insurer, including the provision being made for notice to subscribers and enrollees, group representatives and providers of health care services who contract with the plan.

5. If the plan or any provider of health care services to the plan holds medical records as to any subscriber or enrollee, indicate the disposition to be made of such records, including the provision made for its subsequent availability to persons providing health care services to such subscribers and enrollees.

e. Is the plan's application pursuant to Section 1351 of the Knox-Keene Health Care Service Plan Act of 1975 current, reflecting all matters which require an amendment to such application pursuant to Rules 1300.52, 1300.52.1 or 1300.52.2?

Yes [ ] No [ ]

If "no" attach an amendment(s) to such application in conformance with such rules

f. Is the plan currently involved in any civil or administrative proceeding?

Yes [ ] No [ ]

If "yes" furnish full details, including the court or administrative action before which such matter is pending.

6. The licensee has duly caused this application to be signed on its behalf by the undersigned, thereunto duly authorized.

_____
(Licensee)
By _____

Title _____

I certify under penalty of perjury that I have read this application and the attachments hereto and know the contents thereof, and that the statements therein are true.

Executed at _____ on _____

_____
Signature of Declarant

If executed in a jurisdiction which does not permit verification under penalty of perjury, attach a verification executed and sworn to before a notary public.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1399, Health and Safety Code.

HISTORY:

1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
2. Amendment filed 7-3-84; effective thirtieth day thereafter (Register 84, No. 27).
3. Change without regulatory effect amending subsection (e) filed 4-4-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 14).
4. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
5. Change without regulatory effect amending section filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).

§ 1300.99.7. Application for Conversion or Restructuring.

An application for conversion or restructuring pursuant to Article 11 (commencing with Section 1399.70) of the Act shall be filed as a Notice of Material Modification pursuant to Rule 1300.52.1.

NOTE: Authority cited: Sections 1344 and 1399.74, Health and Safety Code. Reference: Sections 1352, 1399.70, 1399.71, 1399.72, 1399.73, 1399.74 and 1399.75, Health and Safety Code.

HISTORY:

1. New section filed 6-20-96 as an emergency; operative 6-20-96 (Register 96, No. 25). A Certificate of Compliance must be transmitted to OAL by 10-18-96 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 10-15-96 as an emergency; operative 10-18-96 (Register 96, No. 42). A Certificate of Compliance must be transmitted to OAL by 2-12-97 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 10-15-96 order transmitted to OAL 2-3-97 and filed 2-24-97 (Register 97, No. 9).

ARTICLE 15
Charitable or Public Activities

Section