

**STATE OF CALIFORNIA
MANAGED RISK MEDICAL INSURANCE BOARD
1000 G STREET, SUITE 450
SACRAMENTO, CA 95814**

**TITLE 10. INVESTMENT. CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.8. MANAGED RISK MEDICAL INSURANCE BOARD
HEALTHY FAMILIES PROGRAM
ARTICLE 1. DEFINITIONS
AMEND SECTION 2699.6500 (r)**

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Section 2699.6500 is amended to read:

2699.6500. Definitions.

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- (r) “Family value package” means the combination of participating health, dental, and vision plans available to subscribers in each county offering the lowest price and each of the combinations offering a price within seven and one half percent (7.5%) of the average price of the lowest priced combination and the second lowest price combination of health, dental, and vision plans. The second lowest price combination is calculated by summing the second lowest price health plan, the second lowest price dental plan, and the second lowest price vision plan. If only one health, dental, or vision plan is available to subscribers in a county, the price of the one available plan shall be used in the calculations of the second lowest price combination. A health, dental, or vision plan with a service area which does not include zip codes in which at least eighty-five percent (85%) of the residents of the county reside or that has enrollment limits unrelated to network capacity shall not be considered the lowest or second lowest price plan, unless it is the only health, dental, or vision plan in the county. In addition, any combination of health, dental, and vision plans in which the health, dental, and vision plan are each available in at least one plan combination that is within seven and one half percent (7.5%) of the average price of the lowest and second lowest price combination of health, dental, and vision plans, is a family value package. In all family value package calculations, the health plan rate to be used is

the rate for subscriber children from one year old up to the age of nineteen. The dental and vision plan rates to be used are the rates for subscriber children. ~~The family value package determinations shall be made once each year by the Board, no later than the last day of March for the following benefit year, based on calculations using the prices of the plans that at the time of the calculations are expected to be available the following benefit year.~~ *When the Board calculates the family value package, it shall base the calculation on the plan prices expected to be available for the anticipated health, dental and vision plan contract terms.* Calculations will not be redone if plans are later dropped from or added to a county. However, if the Board at any time determines that the seven and one half percent (7.5%) level is insufficient to assure that adequate network capacity exists in a specified county so that all subscribers may be enrolled in a family value package, the Board may increase the percentage for that county to a percentage at which sufficient capacity is assured. Such increased percentage shall be in effect only for the benefit year in which the increase is made. The Board may determine, if requested as a part of a rural demonstration project for a special population, that a combination of health, dental, and vision plans in a county with a price higher than the family value package may still be deemed a family value package for applicants and subscribers that are members of the special population; in addition the Board may determine, if requested as part of a rural demonstration project for rural area residents, that a combination of health, dental, and vision plans in a county with a price higher than the family value package may still be deemed a family value package for subscribers that are residents of the rural area. The Board may determine that a combination of health, dental, and vision plans in a county that includes health and vision plans available in at least one family value package plan combination is deemed a family value package even if the dental plan is not in any other family value package plan combination, but only for applicants with subscribers who are enrolled prior to the beginning of the benefit year in that dental plan, and only if the Board determines it necessary in order to avoid requiring fifty percent (50%) of subscribers or one-thousand (1,000) subscribers in a county to change their dental plan.

* * * [continued]

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.02, 12693.03, 12693.045, 12693.06, 12693.065, 12693.08, 12693.09, 12693.10, 12693.70, 12693.105, 12693.11, 12693.12, 12693.13, 12693.14, 12693.16, 12693.17, 12693.755 and 12693.91, Insurance Code.

**TITLE 10. INVESTMENT. CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.8. MANAGED RISK MEDICAL INSURANCE BOARD
HEALTHY FAMILIES PROGRAM
ARTICLE 4. RISK CATEGORIES AND FAMILY CONTRIBUTIONS
AMEND SECTIONS 2699.6805(f) and 2699.6803**

Text

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Section 2699.6803 is amended to read:

2699.6803. Annual Health, Dental and Vision Benefit Plan Rates.

Health, dental and vision benefit plan rates shall be established for each *contract term* rating period and the rating period for the program shall be a twelve (12) month period.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.21, Insurance Code.

Section 2699.6805 is amended to read:

2699.6805. Designation of Community Provider Plan

(a) For each benefit year, the Board will designate as the community provider plan in each county the participating health plan with a service area which includes zip codes in which at least eighty-five percent (85%) of the residents of the county reside that has the highest percentage of traditional and safety net providers pursuant to the calculation in (e) below.

(b) By the end of November of each year, the Board shall compile and make available a list for each county of all Child Health and Disability Prevention Program (CHDP), clinic and hospital traditional and safety net providers.

(c) The lists shall be compiled as follows:

(1) The CHDP list shall include all CHDP providers, except for clinical laboratories, that were on the Department of Health Care Services ~~(DHS)~~(DHCS) CHDP Master File as of October 1st of that year and which provided a State-Only

Funded CHDP service as identified on the CHDP Paid Claims Tape to at least one (1) child in the state fiscal year that ended immediately prior to the most recently ended state fiscal year. For each provider, the list shall indicate the percentage of county children that received State-only funded CHDP services from the identified provider. The number of county children shall be calculated by summing the numbers of children that received State-only funded CHDP services from each listed provider.

(2) The clinic list shall include all community clinics, free clinics, rural health clinics, and county owned and operated clinics, located in the county, which were so identified by the Medi-Cal program as of October 1st of that year and which were identified on the Medi-Cal Paid Claims Tape as having provided service to at least one (1) child aged one (1) through eighteen (18) in the state fiscal year that ended immediately prior to the most recently ended state fiscal year. For each clinic, the list shall indicate a percentage which shall be equal to one (1) divided by the number of listed clinics in the county.

(3) The hospital list shall include:

(A) For a county that has, located in the county, at least one hospital which was as of October 1st of that year a hospital eligible for the inpatient disproportionate share hospital payment program as reported by the Department of Health Care Services, a University teaching hospital, a Children's Hospital (as defined in Section 10727 of the Welfare and Institutions Code), or a county owned and operated general acute care hospital, the list shall include all hospitals of one of these types whether or not they are located in the county which reported to the Office of Statewide Health Planning and Development (OSHPD) discharging at least one resident of the county who was a Medi-Cal, county indigent and charity care patient aged one (1) through eighteen (18) in the year for which OSHPD most recently released its annual compilation of Discharge Data. For each hospital, the list shall indicate the percentage of the Medi-Cal, county indigent, and charity care discharges from all listed hospitals of county residents aged one (1) through eighteen (18) that were from the identified hospital.

(B) For all other counties, the list shall include all hospitals located in the county and all hospitals which discharged at least one resident of the county who was a Medi-Cal, county indigent or charity care patient aged one (1) through eighteen (18) in the year for which OSHPD most recently released its annual compilation of Discharge Data and which were a hospital eligible for the inpatient disproportionate share hospital payment

program as reported by the ~~DHS~~ *DHCS*, a university teaching hospital, a children's hospital (as defined in Section 10727 of the Welfare and Institutions Code), or a county owned and operated general acute care hospital. For each hospital the list shall indicate the percentage of the Medi-Cal, county indigent, and charity care discharges from all listed hospitals of county residents aged one (1) through eighteen (18) that were from the identified hospital.

(d) By January 15th of each year, each participating health plan shall submit to the Board for each county the following:

(1) A list of the CHDP providers identified by the Board pursuant to (c)(1) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(2) A list of the clinics identified by the Board pursuant to (c)(2) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(3) A list of the hospitals identified by the Board pursuant to (c)(3) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(e) The percentage of traditional and safety net providers in the provider network of each participating health plan will be calculated by summing the CHDP percentage, the clinic percentage, and the hospital percentage.

(1) The CHDP percentage is calculated by summing the percentages assigned to all CHDP providers in the county identified by the plan pursuant to (d)(1), and multiplying that number by 0.35.

(2) The clinic percentage is calculated by summing the percentages assigned to all clinics in the county identified by the plan pursuant to (d)(2), and multiplying that number by 0.45.

(3) The hospital percentage is calculated by summing the percentages assigned to all hospitals in the county identified by the plan pursuant to (d)(3), and multiplying that number by 0.2.

(f) The Board shall ~~announce~~ *designate* ~~a the designation of the~~ community provider plan for each county ~~by March 31st of each year for the benefit year beginning on the next July 1st.~~ *described in subsection (a).* *Notwithstanding subsection (h) of section*

2600.6500, the designation shall take effect on the day the open enrollment transfers described in section 2699.6621 take effect, and the previous designation shall remain in effect until that time. Prior to designation, each plan's relationships with traditional and safety net providers may be verified by the Board.

(g) The lists of CHDP providers in (c)(1), clinics in (c)(2) and hospitals in (c)(3) shall only be revised under the following circumstances:

(1) Any CHDP provider not included on a county list pursuant to (c)(1) that believes it met the specified criteria to be on that list and was excluded in error, may within thirty (30) calendar days after the list is released by the Board, notify the Board that it so believes and provide written documentation demonstrating that it met the listed criteria. If the Executive Director of the Board finds that the CHDP provider did meet the specified criteria it shall be added to the county list.

(2) Any clinic not included on a county list pursuant to (c)(2) that believes it met the specified criteria to be on that list and was excluded in error, may within thirty (30) calendar days after the list is released by the Board, notify the Board that it so believes and provide written documentation demonstrating that it met the listed criteria. If the Executive Director of the Board finds that the clinic did meet the specified criteria it shall be added to the county list.

(3) Any hospital not included on a county list pursuant to (c)(3) that believes it met the specified criteria to be on that list and was excluded in error, may within thirty (30) calendar days after the list is released by the Board, notify the Board that it so believes and provide written documentation demonstrating that it met the listed criteria. If the Executive Director of the Board finds that the hospital did meet the specified criteria it shall be added to the county list.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21 and 12693.37, Insurance Code.