

**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
AMEND SECTION 2699.6500 (r); 2699.6803; 2699;6805**

ARTICLE 1. DEFINITIONS

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Text proposed to be deleted is displayed in ~~strikeout~~ type.

Section 2699.6500 is amended to read:

2699.6500. Definitions.

* * *

- (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.

**ARTICLE 4. RISK CATEGORIES AND FAMILY CONTRIBUTIONS
AMEND SECTIONS 2699.6805(f) and 2699.6803**

Text

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Text proposed to be deleted is displayed in ~~strikeout~~ type.

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~~ that includes zip codes in which at least eighty-five percent (85%) of the residents of the county reside and that has the highest percentage of traditional and safety net providers pursuant to the calculation in subsection ~~(e)~~(g) below.

(b) By the ~~end~~ first day of November of ~~each year~~ the benefit year immediately preceding the benefit year described in subsection (a), 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~~ the benefit year immediately

preceding the benefit year described in subsection (a) and which that provided a State-Only Funded State-only funded CHDP service as identified on the CHDP Paid Claims Tape 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 listed provider, the list shall indicate the percentage of county children that received State-only funded CHDP services from the identified listed 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. The percentage shall be calculated by dividing the number of county children receiving State-only funded services from the listed provider by the total number of county children receiving State-only funded services from all listed providers in the county.

(2) ~~The clinic list shall include all community clinics, free clinics, rural health clinics, and county owned and operated clinics, located in the county, Community Outpatient Hospital Based Clinics, Rural Health Clinics, Federally Qualified Health Centers, Free Clinics, Community Clinics, Clinics Exempt from Licensure, County Clinics Not With Hospital and County Hospital Outpatient Clinics, in the county, which that~~ were so identified by the Medi-Cal program as of October 1st of ~~that year~~ the benefit year immediately preceding the benefit year described in subsection (a) and which were identified on the Medi-Cal Paid Claims Tape as having provided at least (15) services to children 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~~ The list shall indicate a percentage for each clinic which shall be equal to one (1) divided by the number of listed clinics in the county.

(3) The hospital list shall ~~include~~ be compiled as follows:

(A) For a county that has, located in the county, at least one hospital which, ~~was~~ as of October 1st of ~~that year~~ the benefit year immediately preceding the benefit year described in subsection (a), was a hospital eligible for the inpatient disproportionate share hospital payment program as reported by the Department of Health Care Services (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, the list shall include all hospitals of one of these types whether or not they are located in the county and 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, or ~~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~~ The list shall indicate, for each hospital, 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 listed hospital~~. The hospital list shall not include acute psychiatric hospitals (as defined in Section 1250(b) of the Health and Safety Code), psychiatric health facilities (as defined in Section 1250.2(a) of the Health and Safety Code), or chemical dependency recovery hospitals (as defined in Section 1250.3(a) of the Health and Safety Code).

(B) For all other counties, the list shall include all hospitals located in the county and all hospitals located outside the county, which, as of October 1st of the benefit year immediately preceding the benefit year described in subsection (a), 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 hospitals 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 The list shall indicate, for each hospital, 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 listed hospital. The hospital list shall not include acute psychiatric hospitals (as defined in Section 1250(b) of the Health and Safety Code, psychiatric health facilities (as defined in Section 1250.2(a) of the Health and Safety Code), or chemical dependency recovery hospitals (as defined in Section 1250.3(a) of the Health and Safety Code).

- (d) The lists of CHDP providers, clinics and hospitals described in subsection (c) shall be revised only under the following circumstances:
- (1) Any CHDP provider not included on a county list pursuant to subsection (c)(1) or any participating health plan that asserts the CHDP provider met the specified criteria to be on that list and was excluded in error may, within thirty (30) calendar days after the list described in subsection (b) is released by the Board, provide written documentation to the Board demonstrating that the CHDP provider met the criteria described in subsection (c)(1). If the Executive Director of the Board finds that the CHDP provider met the specified criteria then the CHDP provider shall be added to the county list.

(2) Any clinic not included on a county list pursuant to subsection (c)(2) or any participating health plan that asserts the clinic met the specified criteria to be on that list and was excluded in error may, within thirty (30) calendar days after the list described in subsection (b) is released by the Board, provide written documentation to the Board demonstrating that the clinic met the criteria as described in subsection (c)(2). If the Executive Director of the Board finds that the clinic met the specified criteria then the clinic shall be added to the county list.

(3) Any hospital not included on a county list pursuant to subsection (c)(3) or any participating health plan that asserts the hospital met the specified criteria to be on that list and was excluded in error may, within thirty (30) calendar days after the list described in subsection (b) is released by the Board, provide written documentation to the Board demonstrating that the hospital met the criteria described in subsection (c)(3). If the Executive Director of the Board finds that the hospital met the specified criteria then the hospital shall be added to the county list.

(e) The Board shall compile and make available a final list for each county of all Child Health and Disability Prevention (CHDP), clinic, and hospital traditional and safety net providers after the 30-day revision period described in subsection (d) has expired.

(d)(f) By January 15th of each year, the benefit year immediately preceding the benefit year described in subsection (a), each participating health plan shall submit the following to the Board for each county the following:

(1) A list of the CHDP providers identified by the Board pursuant to subsection (e)(1)(e) 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 subsection (e)(2)(e) 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 subsection (e)(3)(e) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(e)(g) 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 number of CHDP services provided to all children aged one (1) through eighteen (18) by listed CHDP providers within the county that were percentages assigned to all CHDP providers in the county identified by the plan pursuant to (d)(f)(1), and dividing this sum by the number of services provided by all listed CHDP providers in the county 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.~~

(2) The clinic percentage is calculated by:

(A) Adding the percentages assigned to each listed clinic in the county pursuant to subsection (c)(2) that was identified by the plan pursuant to subsection (f)(2), and multiplying that percentage by 0.225; and adding the number produced by the calculation made in subsection (e)(2)(B) below.

(B) Dividing the number of services provided by each listed clinic in the county that was identified by the plan pursuant to subsection (f)(2) by the number of services provided by all listed clinics in the county pursuant to subsection (c)(2), and multiplying that percentage by 0.225.

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

~~(f)(h) 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.

**Summary and Response to Public Comments
Regarding Community Provider Plan (CPP) Designation Timeline
And Modification of Process for CPP**

Public Comments were received from one (1) organization:

1. California Nurses Association/National Nurses Organizing Committee

Specific Comments and Responses

Comment 1a: No Section cited

The commenter stated MRMIB is attempting to adapt to timelines beyond their control due to the budget crisis and current lack of a state budget. They also acknowledge that the proposed regulations are an attempt to prevent harm to children and families and they support all attempts to maintain a fully functional Healthy Families Program.

Response: MRMIB accepts this comment.

Comment 1b: Section 2699.6500 Definitions

The commenter supports MRMIB's efforts to secure the lowest cost plan for families, and understands that this cannot be determined at this time.

Response: This comment is rejected because it is not related to the change being made.

Comment 1c: No Section cited

The commenter stated that the network capacity which is addressed in this emergency regulatory package as background information is important from a clinical point of view and urged MRMIB to not allow the network capacity to be manipulated by competition or collusion to the detriment of health care services.

Response: This comment is not related to the proposed regulation changes and is therefore rejected.

Comment 1d: No Section cited

The commenter is very concerned about the budget discussions and the Governor's plan calling for reductions because the commenter states that it could affect the healthcare of children and families. The commenter urged MRMIB to advocate keeping health care for families and children affordable and accessible for participants.

Response: This comment is rejected because it is not related to regulation changes.



CALIFORNIA
NURSES
ASSOCIATION



NATIONAL NURSES
ORGANIZING COMMITTEE

Agenda Item 8.g.2.
8/7/08 Meeting

A Voice for Nurses. A Vision for Healthcare.
www.calnurses.org / www.nnoc.net

July 7, 2008

Public Comment 1; ER-1-08
CPP Designation Timeline and Modification of Process

Managed Risk Medical Insurance Board
Attn: Joanne French
1000 G Street, Suite 450
Sacramento, California 95814
FAX: 327-6580

RE: ER-1-08

Dear Ms French:

The 80,000 registered nurses of the California Nurses Association/National Nurses Organizing Committee (CNA/NNOC) observe that the MRMIB is attempting to adapt to timelines beyond their control due to the budget crisis and the current lack of a state budget. We understand that the proposed Emergency Regulations are an attempt to prevent harm to children and families in the process, and we support all attempts to maintain a fully functional Healthy Families Program.

The following proposed changes; section 2699.6500 Definitions (in relevant part) is changed from ~~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 process of the plans that at the time of the calculations are expected to be available the following benefit year.~~ To the amended language (in relevant part), *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 contract terms.* We support MRMIB's efforts to secure the lowest cost plan (amongst comparable and comprehensive coverage) for families, and understand that this can't be determined at this time.

We further agree that the network capacity which is addressed in the Emergency Regulatory package as background is certainly important from a clinical point of view. We would urge MRMIB to assure that network capacity not be allowed to be manipulated by health care company competition, or collusion to the detriment of the health care services that are of utmost importance.

CNA/NNOC is very concerned about the budget discussions that affect the healthcare of children and families; such as the Governor's plan calling for 6.25% reduction in current contract capitation payments for HFP participating health, dental and vision; and the Governor's proposed budget including a premium increase for applicants with incomes above 150% of the federal poverty level.

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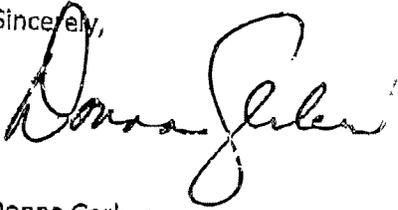
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MAINE
160 Capitol St. #1
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CNA/NNOC urges the MRMIB to advocate for the children and families that Health Families was created to prioritize and to keep health care affordable and accessible for all participants.

Sincerely,

A handwritten signature in black ink, appearing to read "Donna Gerber". The signature is written in a cursive style with a large, looping initial "D".

Donna Gerber
Director of Government Relations



Chad Westover
Vice President
State Sponsored Business
5151A Camino Ruiz
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Submitted via email: jfrench@mrmib.ca.gov

July 7, 2008

JoAnne French
Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, California 95814

RE: Proposed Rule-Making ER-1-08

Dear Ms. French:

On behalf of Anthem Blue Cross of California, we thank you for the opportunity to provide feedback on the California Managed Risk Medical Insurance Board's (MRMIB) proposed rule-making ER-1-08 which addresses the Community Provider Plan (CPP) designation process. Anthem supports the proposed changes made via this rulemaking, but we do have some concerns regarding the CPP timeline in future years. Below are our comments.

Compiled Lists

We specifically support MRMIB's action in clarifying that hospitals located outside a given county which serve a Medi-Cal, county indigent, or charity child from that county are to be included on the hospital list. This is a good policy as it recognizes all hospitals that provide care to residents of a particular county.

List Revisions

Anthem also strongly supports the proposed action which would authorize any participating health plan to propose a revision to the CHDP, clinic, or hospital lists. This grants plans the ability to request revisions without having to depend on providers.

CPP Designation

Anthem fully supports MRMIB's March 2008 emergency action in modifying the time frames for the CPP designation process, deleting the March 31st announcement date for the benefit year beginning July 1st, due to the uncertainty surrounding this year's California budget process and potential program altering changes. However, we request that this change remain a temporary emergency change, as opposed to a permanent programmatic change.

The emergency change takes into account the unique situation of this budget year, without making changes to the process in future years. Concrete deadlines should remain in permanent regulation to provide stability and certainty to the CPP process going forward. The CPP submission process consumes considerable health plan resources and the required logistics cannot be efficiently planned or scheduled without permanent dates set out in regulation.

This has a large impact on current Healthy Families enrollees and their family members who anticipate open enrollment to make changes. Permanence and consistency in the process dates year after year is essential.

Thus, we propose retaining the set dates in the permanent regulation with the recognition that MRMIB can invoke an emergency delay for any year going forward.

If you have any questions or concerns, please contact me at

Sincerely,

Anthem Blue Cross

A handwritten signature in black ink, appearing to read "Chad Westover". The signature is written in a cursive, flowing style.

Chad Westover
Vice-President

PUBLIC HEARING ON ER-1-08

R Turner: Good afternoon. This hearing is being recorded electronically. The transcript of the hearing and all exhibits and evidence presented during the hearing will be made part of the rulemaking record. The rulemaking record includes the (A) notice of the proposed action which was published in the California Regulatory Notice Register, (B) the express terms of the proposed action, using underline and strikethrough format of the California Code of Regulations, (C) the statement of reasons, and (D) written comments received to-date.

I am Randi Turner, Chief of the Human Resources and Program Support Section, which includes the Regulations Unit, for the Managed Risk Medical Insurance Board (Board).

It is Monday, July 7, at 2:33 p.m. We're meeting in the offices of the Managed Risk Medical Insurance Board, 1000 G Street, Suite in 450, Sacramento, California, in the Front Conference Room, for the purpose of receiving public comments on a proposed rulemaking action by the Board to make changes to Chapter 5.8 of Title 10 of the California Code of Regulations. Evidence in writing from interested parties will be accepted until 5:00 p.m. today. Any comments received after 5:00 p.m. today will be considered late and will not be accepted.

I normally say here, "Has anyone brought written comments that you would like to submit?" and Donna has already said "yes," so we'll move on with the next part of this.

In 1997, the Federal Government established the State Children's Health Insurance Program (SCHIP), by adding Title XXI to the Social Security Act. Pursuant to AB 1126 (Chapter 623, Statutes of 1997), California established a SCHIP insurance program called Healthy Families Program (HFP). The program is administered by the Managed Risk Medical Insurance Board (MRMIB). HFP is targeted to serve children whose family income, although low, is too high to qualify for the Title XIX Medicaid Program, called Medi-Cal in California. The structure of HFP is set out in Insurance Code Section 12693, et seq. and Chapter 5.8, Title 10 of the California Code of Regulations.

AB 1126 contained provisions to ensure MRMIB provides each HFP applicant a choice of providers, including Traditional and Safety Net (T&SN) providers. The statute creating the CPP designation process provides: 1) stability for the T&SN providers who had historically provided services to children who would qualify

for HFP when the program began; 2) continuity of care for newly enrolled HFP members; 3) inclusion of providers who share cultural and linguistic characteristics with the HFP population; and 4) incentive for plans to contract with a variety of providers to ensure subscribers' choice and access to services among providers. MRMIB was directed to determine which plan in each county had done the best job of including T&SN providers in its network and to designate that plan the Community Provider Plan (CPP) in any given county.

When the CPP process was under development, stakeholders provided input about the various methods that could be used to develop the T&SN lists and designate the CPP winner in each county. Based on that input, MRMIB adopted regulations to compile three separate lists of T&SN providers each year: 1) a list of T&SN hospitals (weighted 20 percent), 2) a list of T&SN clinics (weighted 45 percent), and 3) a list of T&SN Child Health and Disability Program (CHDP) providers (weighted 35 percent).

In 2006, several stakeholders submitted requests to change and/or clarify the CPP designation process. MRMIB evaluated the stakeholders' requests and determined that some of the recommendations provided by stakeholders would improve the CPP designation process.

Under the provisions of the California Administrative Procedure Act, this is the time and place set for the presentation of statements, arguments and contentions, orally or in writing, for or against the changes in the Board's regulations. The notice of this proposal has been published on MRMIB's website, in the California Regulatory Notice Register and has been sent by mail to interested parties.

This is a quasi-legislative hearing to carry out rulemaking functions delegated to the Board by the Legislature. Witnesses presenting testimony at this hearing will not be sworn in, nor will we engage in cross-examination of witnesses. We will take under submission all written and oral statements submitted or made during this hearing. We will respond to these comments in writing in the final statement of reasons.

We will notify all those who signed in and provided addresses, before the final adoption of any changes to this proposal or about any new material relied upon in proposing these regulations. Such notice will be sent to everyone who submits written comments during the written comment period, including those written comments submitted today, to everyone who testifies today, and to

everyone who asks for such notification. While no one may be excluded from participation in these proceedings for failure to identify themselves, the names and addresses on the attendance sheet will be used to provide the notice. You both signed in so I'm not going to tell you to sign in.

We will listen to oral comments in the order provided, so that's you Donna. When you speak, please begin by stating your name and identifying the organization you represent, if any, and tell us the section number of the particular regulation you want to discuss.

At this point we will now take oral comments now. I'm going to leave off this last because there are no other speakers that you need to concur with. So Donna if you're ready go ahead.

D Fox: Thank you, I'm Donna Fox from California Nurses Association and I appreciate MRMIB's staff efforts to help me understand the purpose of these particular regs and I did read through them to understand why they are emergency regs. At this point it appears to me that MRMIB is trying to respond to timelines, all of which are beyond their control, and trying to plan in a sort of defensive posture so that program rollbacks do not occur to the extent that MRMIB can do that. That's how I read the emergency nature in the justification for that. So this letter which I'm reading from may be altered slightly but we'll get you a written copy by 5 today. It is in the spirit of looking at these regs from that point of view that MRMIB wants to continue to provide healthcare for children and families. I certainly understand why network capacity is important from a clinical point of view, we do. 80,000 registered nurses from CAN, but we would urge MRMIB, Healthy Families, to not allow the network capacity to be used in any way and manipulated or any collusion such that the business aspects are better served than the patients. This is not a particular comment related only to these regulations but it does seem that the conditions that could favor the business interests exists and given the fact, as was addressed in the emergency regs, that the governors calling for 6.5 reduction on the capitation and he's also saying (proposing) families should pay a premium increase, those families that have incomes above 150% of poverty, those concerns are of paramount importance to us. 150% of federal poverty is still quite low to low middle income in California especially at this time where many families, and increasingly, families are losing income and paying more for their basic human needs. We would like MRMIB to continue to prioritize the children and families, which Healthy Families was designed to serve, and urge you to keep to your best abilities healthcare affordable and accessible for all. And we would be very interested

in what you referenced earlier, any ongoing feedback. So in addition to any routine announcements that may come out for regs because there are so many issues up in the air because so many budget issues are up in the air and from, I'll say, "our" but I really mean "my point of view" there's a fair amount of complexity from the outside of what plans do and what family value package is and there are lots of variables. Then there's the special rural demonstration project, so there's a lot of things that can change in interactive ways once some issues are known. So while we will continue to advocate with the legislature, as we always do, our interest is to have as much current information as possible of what is occurring.

R Turner: Okay, we do have the regs mailing list which was how you were notified of this. That will continue to go out; as far as other things that are happening, I would encourage you to refer you back to our public website or even to contact any of the program managers or the director if there is something specific that you want in other areas as well. My jurisdiction here is to just take your comments about the regulations. Anything else?

D Fox: I'd rather, in case this gets altered a little, rather to avoid confusion I'll see if it's been altered and fax an e-mail by 5:00. Okay?

R Turner: Okay, I will turn this off, unless you have any other comments. No? Okay.

**MANAGED RISK MEDICAL INSURANCE BOARD
RESOLUTION**

After considering the public comments submitted to the Board, the Board hereby approves the final adoption of the Healthy Families Program Community Provider Plan (CPP) Timeline Designation and Process Modification Regulation Package ER-1-08.

* * * * *

CERTIFICATION

I, Lesley Cummings, Executive Director of the Managed Risk Medical Insurance Board, do hereby certify that the foregoing action was duly passed and adopted by the Managed Risk Medical Insurance Board at an official meeting thereof on August 7, 2008.

Dated this 7th day of August, 2008.

Lesley Cummings, Executive Director
Managed Risk Medical Insurance Board