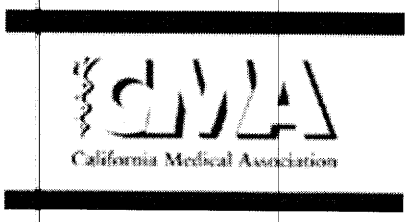


SynerMed
Innovating Healthcare

August 6, 2012

Peter Lee
Executive Director
California Health Benefit Exchange
2535 Capitol Oaks Drive, Suite 120
Sacramento, CA 95833

RE: PROPOSED DEFINITION OF ESSENTIAL COMMUNITY PROVIDER

Dear Mr. Lee:

The undersigned coalition of physicians, clinics, medical groups, health plans and disproportionate share hospitals strongly supports the Exchange staff recommendation regarding the definition of Essential Community Provider. The recommended definition appropriately encompasses the broader group of ***public and private*** providers who have traditionally served Medi-Cal beneficiaries and the uninsured.

Defining Essential Community Provider

We largely support the current staff recommendation (Option B) regarding the definition of Essential Community Provider, with some modifications and suggestions to address the need to determine "high volume." We propose that Essential Community Providers be defined as including all of the following:

> (1) Health care providers defined in section 340B(a)(4) of the Federal Public Health Service Act.
>
> (2) Providers described in section 1927(c)(1)(D)(i)(IV) of the Federal Social Security Act as set forth by section 221 of Public Law 111-8.
>
> (3) Providers that serve predominately low-income, medically underserved individuals, consisting of the following:
>
> (i) Public and private hospitals designated by the California Department of Health Care Services as a disproportionate share hospital, as defined in Section 14166.1 (d), (f), or (j) of the Welfare and Institutions Code, and children's hospitals.
>
> (ii) Any freestanding county clinic or clinic associated with a disproportionate share hospital as defined by 14166.1 (d), (f), or (j) of the Welfare and Institutions Code.
>
> (iii) A medical group, independent practice association, physician office, or clinic with more than 10 physicians that has a Medi-Cal or medically indigent encounter rate of at least 50 percent of total patients served.
>
> (iv) A medical practice of 10 or fewer physicians in which at least 30 percent of patients served are uninsured or enrolled in Medi-Cal in the case of a primary care physician practice, or 20 percent of patients served in the case of a specialty care physician practice.

This definition would meet the federal requirement to define Essential Community Providers as providers who "serve predominately low-income, medically underserved individuals."

We strongly ***oppose*** narrowing the definition to include only those providers defined in section 340B (a)(4) of the Public Health Service Act and 1927(c)(1)(D)(i)(IV) of the Social Security Act ("340B or 1927(c) providers").

As your briefing paper points out, the state has flexibility under federal law to define which providers constitute Essential Community Providers for the purposes of Qualified Health Plan certification. Many providers in California who are not 340B or 1927(c) providers have made a significant investment in serving predominately low-income, medically underserved individuals and the state's public programs, such as Medi-Cal, AIM and Healthy Families. Our reasons for including these providers in the definition are as follows:

- ***Ensuring Continuity of Care:*** The main goal of including Essential Community Providers in health plan networks—to the degree that they are not already included—should be to maintain continuity of care. Many individuals who purchase coverage in the Exchange may have been previously uninsured or eligible for a public program and may have a relationship with or may be actively under the care of providers who have traditionally served this population. The providers that we have identified in the proposed definition above have a track record of not only serving the Medi-Cal population, but also treating the uninsured, often at a significant discount over Medi-Cal or fee-for-service rates.

- ***Ensuring Continuity of Provider:*** Independent physicians and medical groups are already serving a substantial percentage of the uninsured population as part of their practice, and some have specialized in offering the culturally and linguistically appropriate care this population needs. The uninsured are likely to receive the greatest benefit from the soon-to-be-established Exchange because they have been obtaining care as cash patients. These patients are most likely to be the Exchange's first customers, and ensuring that independent physicians—who have invested in caring for this population—are considered Essential Community Providers will help these members maintain their traditional medical home and minimize disruption.

- ***Ensuring Access to Care and Network Adequacy:*** Many community clinics and other 340B and 1927(c) providers are already at capacity. Requiring all QHPs to contract with this very small group of providers would unnecessarily limit QHP networks and likely result in diminished access to care.

- ***Ensuring Access in Underserved Communities***: In a state as geographically expansive as California, which includes vast agricultural regions, there is also the need for adequate geographic coverage of Essential Community Providers due to the projected 50 percent churn rate for those under 200 percent of the Federal Poverty Level and the need for continuity of care. Using only 340B and 1927(c) providers would be insufficient. If the Exchange were to designate only hospital and non-hospital 340B and 1927(c) providers as Essential Community Providers, the geographic coverage of inpatient and outpatient Essential Community Provider networks would leave large regions of the state with questionable access to care. Adopting the broader Essential Community Provider definition allows for greater geographic coverage by QHPs in underserved areas.

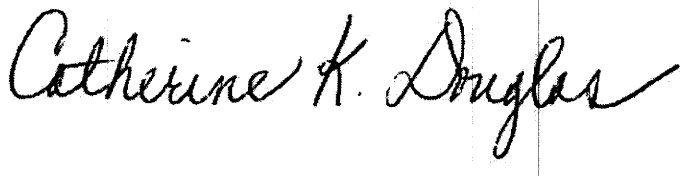
- ***Improving Quality of Care:*** In order to improve quality of care, providers must have to meet quality indicators in order to be included in network. Requiring plans to contract with a very narrow set of specific providers gives those providers leverage over plans, reduces or eliminates competition on quality, and in some areas requires plans to contract with specific providers regardless of their quality metrics. We believe that the broader definition of Essential Community Provider is consistent with the Exchange's mission statement to encourage an "innovative, competitive marketplace" and drive quality improvement.

Utilization of Essential Community Providers in QHP Networks
We also recommend that the Exchange ensure QHP utilization of Essential Community Providers by including it as one of the criteria for QHP approval and renewal in the Exchange.

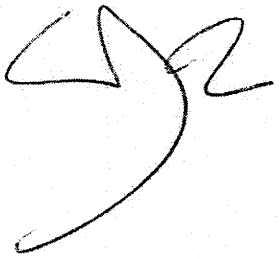
Thank you again for the opportunity to provide input on this critical component leading to the Exchange's October 2013 pre-enrollment efforts and beyond. We look forward to continuing to work with the Exchange Board and staff to realize the vision of improving the health of all Californians by assuring access to affordable, high quality care.

Respectfully Submitted,

Richard Chambers
President, Molina Healthcare of California



Catherine K. Douglas, President & CEO
Private Essential Access Community Hospitals



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