CPCA
California Primary Care Association
Health Care Access for All

California Primary Care Association Policy Priorities for Qualified Health Plans
Policy Recommendations for the California Health Benefits Exchange

CPCA supports the Exchange's vision of playing an active role in the transformation of California's health care delivery system. We believe that successful implementation of the Affordable Care Act (ACA) means transforming how we deliver health care for both the newly-insured and the remaining uninsured, and that community clinics and health centers are a necessary component of a primary care provider network capable of serving all Californians, regardless of insurance status.

Priority 1: Essential Community Provider Definition
In the report "*Qualified Health Plan Policies and Strategies to Improve Care, Prevention, and Affordability,"* the Exchange proposes to significantly broaden the federally recommended definition of "essential community providers," which was limited to "providers that serve predominately low-income, medically underserved individuals, including…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. The report recommends that the "essential community providers" designation be broadened to include physicians, clinics, and hospitals which have "demonstrated service" to the Medi-Cal, low-income, and medically underserved population, and suggested that "demonstrated service" be defined as a patient mix of 30% Medi-Cal for primary care providers, and 20% Medi-Cal for specialists.

CPCA strongly believes that a standard as overly-broad as that proposed by the Exchange is not consistent with Section 156.235 of the ACA Rules that requires providers serve "predominately low-income, medically underserved individuals." This standard falls short of Merriam-Webster definition of "predominant" as being "most frequent or common," implying the regulations warrant a threshold that goes beyond the 30% Medi-Cal proposed by the Exchange.

Community clinics and health centers have for decades consistently served the greatest number of patients who are "predominately" low-income and medically underserved. CCHCs have served over 60% of California's Medi-Cal populations in addition to our long-standing commitment to serve the uninsured that other providers have turned away.

CPCA strongly believes that to be a true essential community provider, one must serve all members of a community, regardless of their ability to pay. **CPCA recommends that the Exchange define essential community provider as:**

> **"Those groups suggested within the Affordable Care Act, namely those included in section 340B(a)(4) of the Public Health Service Act and in Section 1927(c)(1)(D)(i)(IV) of the Social Security Act, as well as those entities licensed as**

either a "community clinic" or "free clinic" by the State under California Health & Safety Code §1204(a)(1) and (2), or is exempt from licensure under Section 1206."

Priority 2: Essential Community Provider Network Sufficiency
In their recent report, the Exchange proposes to measure the "sufficient participation" of essential community providers by showing some amount of overlap between a qualified health plan's provider network and Medi-Cal Managed Care or Healthy Families networks, or independent physicians serving a high volume of Medi-Cal patients.

CPCA is concerned that no aspect of this "sufficient participation" standard takes into account the need to ensure that services are available to low income, medically underserved populations outside of the Medi-Cal population. Moreover, no part of this "sufficient participation" guideline requires or even encourages the inclusion of the 340(B) or Section 1927 essential community providers as defined by the federal standards.

CPCA strongly believes that **the Exchange should impose transparent standards to evaluate the "sufficient participation" of essential community providers in health plan networks** in every service area by utilizing the Department of Managed Health Care standards regarding ratio of primary care providers to population, timely access, adequate language access, and cultural competence. Without meaningful metrics by which to measure "sufficient participation," low income, medically underserved populations are at risk to continue being underserved, and true essential community providers may not have the opportunity to meaningfully participate in the Exchange.

Priority 3: Payment Rates to Federally Qualified Health Centers
CPCA is concerned that the Exchange staff are recommending to the board that QHPs not be required to contract with FQHCs, and that QHPs are not required to pay FQHCs their PPS rate. PPS reimbursement provides for comprehensive, bundled, patient-centered services, which include dental, mental health, pharmacy, primary care, immunizations, chronic care management, care-coordination, interpreters, and much more, thereby keeping patients out of the emergency room and preventing hospitalization. This comprehensive set of bundled, patient-centered services also result in better outcomes for patients, keeps cost down and prevents hospitalization – all goals consistent with ACA.

Through the bundled PPS payment system, health centers have pioneered the high quality, cost-effective service delivery model that the rest of the health care system is now trying to emulate. By not requiring PPS payment, the Exchange is undervaluing the quality, comprehensive care that is the hallmark of the FQHC and the savings that this will provide to health care costs and the improved health outcomes for patients.

While it's disheartening that the Exchange will not require contracting with FQHCs at their PPS rate, **CPCA encourages the Board to adopt Option D**, which will allow the Exchange to assign greater weight to QHP networks that include in-network FQHCs during the QHP evaluation

process. CPCA hopes that this no-cost incentive will encourage QHPs to offer quality FQHC services to their beneficiaries.

Priority 4: Creation of a "Community Benefit Plan"

In much the same vein as the adoption of "Option D," above, CPCA hopes that the Exchange Board will consider further prioritizing the inclusion of CCHCs and their comprehensive, high quality services through the creation of a "community benefit plan."

This plan is similar to the Community Provider Plan model successfully utilized in the Healthy Families program. The success of this model is based upon the ability to bring low-income underserved populations into care through the incentive of discounted premiums, and the partnerships between providers and health plans that translate into greater quality of care for hard to reach populations. With the goal of ensuring safety-net provider participation and bringing critical populations into coverage, **CPCA encourages the Board to designate a Community Benefit Plan in every region, which is the participating health plan with the highest percentage of true essential community providers within it network.** Subscribers selecting the Community Benefit Plan should be given a premium discount, have lower out-of-pocket maximums, or otherwise be incentivized to select the plan.