Contra Costa & Solano Counties

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August 6, 2012

California Health Benefit Exchange
2535 Capitol Oaks Drive, Suite 120
Sacramento, CA 95833

RE: Qualified Health Plan Policies and Strategies to Improve Care, Prevention, and Affordability

Dear California Health Benefit Exchange Staff,

On behalf of Community Clinic Consortium (Consortium), which represents four community health centers (CCHCs) in Contra Costa and Solano Counties including Community Medical Centers, LifeLong Medical Care, La Clinica de La Raza, and Planned Parenthood Shasta-Pacific, I thank you for the opportunity to comment on the July 16 report "Qualified Health Plan Policies and Strategies to Improve Care, Prevention, and Affordability." As a consortium of health centers that provides quality, comprehensive care to all who walk through the door regardless of their ability to pay, we look forward to working with the Exchange to realize the goals of improving health care quality, lowering costs, and reducing health disparities.

Background

The Consortium's member health centers operate 24 sites in two counties, serving more than 135,000 patients, 97% of whom are below 200% of the federal poverty level. Approximately 55% of our patient population is uninsured and 32% receives Medi-Cal. We strive to promote affordability and ensure access to quality care for all individuals. Community health centers work as a catalyst for delivery system reform and are natural organizations to assist newly eligible individuals about health plans and providers in a culturally competent manner.

As a critical safety-net provider in the community that hopes to play an active role in the provision of care for Exchange patients, we respectfully submit the following comments:

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;

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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.

The Consortium 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. Along with other CCHCs in California, we have served over 60% of California's Medi-Cal population in addition to our long-standing commitment to serve the uninsured that other providers have turned away.

The Consortium strongly believes that to be a true essential community provider, one must serve all members of a community, regardless of their ability to pay. For this reason, the Consortium 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)(l)(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)(l) 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 essential community provider network and Medi-Cal Managed Care or Healthy Families networks, or independent physicians serving a high volume of Medi-Cal patients. The Report does not specify what a "minimum proportion of network overlap" might be, which makes it impossible to provide direct feedback on how this recommendation would impact our CCHCs. We strongly encourage the Exchange to establish what constitutes "network overlap" before soliciting feedback on the sufficiency of this recommendation.

Regardless of the actual standard of "minimum proportion of network overlap," the Consortium 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 CCHCs, since under this standard a Qualified Health Plan may meet essential community provider network requirements through contracting with private physician practices, many of whom see a majority of insured patients and already hold contracts with commercial plans.

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Because the recommendation in the report is too vague to effectively evaluate, the Consortium recommends that the Exchange apply DMHC standards regarding ratio of primary care providers to population, timely access, adequate language access, and cultural competence to the essential community provider network (Option A). Should the Exchange develop a standard for "minimum proportion of network overlap" that is effective in encouraging the participation of community clinics and health centers in Qualified Health Plan provider networks, the Consortium would encourage the Exchange to *also* ensure that there is a minimum proportion of network overlap between a Qualified Health Plan network and Medi-Cal and Healthy Families networks (Options A and B together). Without meaningful metrics by which to measure "sufficient participation" and strict standards for inclusion of true essential community providers, low income, medically underserved populations are at risk to continue being underserved, and community clinics and health centers may not have the opportunity to meaningfully participate in the Exchange.

Priority 3: Payment Rates to Federally Qualified Health Centers

The Consortium is concerned that the Exchange staff are recommending to the board that Qualified Health Plans not be required to contract with FQHCs, and that Qualified Health Plans are not required to pay FQHCs their PPS rate. CCHC PPS rate provides for comprehensive, bundled, patient-centered services, which include health education, behavioral health services, patient navigation and necessary linguistic translation services. 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.

In recognition of the value of community clinics and health centers and the cost-effective preventive services they provide to both Medi-Cal and uninsured, sliding-fee patients, the Consortium encourages the Board to adopt Option A (Require Qualified Health Plans to contract with all FQHCs and mandate PPS payment). However, should the Exchange not exercise Option A, the Consortium hopes, at the very least, the Board will adopt Option D, which will allow the Exchange to assign greater weight to Qualified Health Plan networks that include in-network FQHCs during the Qualified Health Plan evaluation process. The Consortium hopes that this no-cost incentive will encourage Qualified Health Plans 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, the Consortium 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.

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With the goal of ensuring safety-net provider participation and bringing critical populations into coverage, the Consortium **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.

If you have any questions about these recommendations, please do not hesitate to contact me. Thank you for your attention and consideration.

Sincerely,

Alvaro Fuentes
Executive Director