January 14, 2013

Mr. Peter Lee
Executive Director
California Health Benefit Exchange
560 J St., Suite 290
Sacramento, CA 95814

SUBJECT: Covered California Bridge Plan Recommendations

Dear Mr. Lee:

On behalf of Private Essential Access Community Hospitals (PEACH), the association representing community safety net hospitals throughout California, we appreciate the opportunity to comment on the January 10, 2013 *Covered California Bridge Plan: Continuity of Care & Affordability Board Recommendation Brief.*

Community safety net hospitals are integral to California's health care safety net, providing significant care to low-income and uninsured Californians throughout the state. All PEACH members are disproportionate share hospitals and, on average, have a patient base that is 70 percent uninsured and government sponsored. ***Among California's safety net hospitals, community safety net hospitals provide nearly half of all care to Medi-Cal patients and nearly half of all emergency care. These hospitals also provide more than one-third of all hospital care to dual eligible Californians. We anticipate that much of the patient population served by community safety net hospitals will move from and between uninsured status, Medi-Cal/SCHIP and Exchange coverage, while another portion will remain uninsured because of their immigration status.***

Because of our fundamental commitment to and long standing relationships with these populations, PEACH strongly supports Covered California's goals of ensuring greater affordability and accessibility of health insurance, reducing churn and ensuring continuity of care while also supporting a strong safety net of Essential Community Providers that will continue to serve more than 3 million uninsured Californians after the Affordable Care Act is implemented.

Of great concern to us is the ability of our vulnerable patient population to access affordable, high-quality health care and the establishment of a safe "healthcare crosswalk" that ensures continuity of care as their eligibility status and life circumstances continually fluctuate.

Therefore, PEACH has the following concerns and questions about the recommendations being considered in the January 10, 2013 brief to meet the goals of affordability, access and continuity of care for our patient population.

I. Covered California Recommendation 1: Covered California Should Contract with Bridge Plans for Transitional Medi-Cal Eligibles and Parents of Medi-Cal/CHIP Children

PEACH sees merit to Covered California contracting with Medi-Cal Managed Care Plans as "Medicaid Bridge Plans," which are intended by the federal government to promote continuity of coverage between Medicaid or CHIP and the Exchange by providing those beneficiaries with access to their existing providers.

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PEACH is supportive of the premise outlined in the January 10, 2013 brief that any Medi-Cal Managed Care Plan that meets the QHP certification requirements could bid to become a Bridge Plan. PEACH also urges Covered California to ensure that all participating managed care plans and providers are paid rates significantly higher than current, historically inadequate Medi-Cal or Medicare rates.

Consumer Choice: While PEACH strongly supports the goal of continuity of care that the Bridge Plans would seek to provide, we are concerned that Bridge Plan beneficiaries are given as much choice as possible to affordable plans and existing safety net providers who have built the care teams and integrated systems to meet their health care needs. The brief recommends that Covered California facilitate continuity of coverage by encouraging, but not requiring individuals, to stay in their prior Medi-Cal Managed Care Plan. However, PEACH is concerned about the additional staff recommendation that the "enhanced affordability option" would only be available if the individual remained enrolled in their current Medi-Cal Managed Care Plan. Since affordability is especially critical to this low-income population, beneficiaries may have no other choice but to stay in a plan that they may otherwise opt out of due to quality or access problems, for example.

Therefore, PEACH encourages Covered California to establish policies that would ensure multiple bridge plans in each given geographical region and that the targeted enrollee population could choose from amongst these plans, (i.e., that there would be more than one second lowest silver plan option with the proposed enhanced affordability available to the targeted population).

Provider Payments: Tables 5 and 6 in the January 10, 2013 Bridge Plan brief (page 13) indicate that Bridge Plan rates may be as high as 103-114 percent of Medicare rates. PEACH requests further clarification about how these estimates were established (For example, is the analysis based on fee-for-service Prospective Payment System Medicare provider payments or Medicare Advantage plan payments?) Without further clarification, and given the fact that average plan administrative costs vary between 6-15 percent, PEACH is concerned that the projected reimbursement rate will not be sufficient for plans to offer fair and reasonable rates to providers.

There is a convergence of circumstances that will be occurring as Covered California begins enrollment in 2013 that will decide, in our opinion, the success or failure of the ACA insurance expansion in California. In 2010, under existing funding, California's hospitals lost $3.7 billion in Medicare payment shortfalls and $4.6 billion in Medi-Cal payment shortfalls–PEACH hospitals incurred a disproportionate share of these losses because of our high concentrations of Medi-Cal and Medicare patients. From what little we know of the Bridge Plan payment expectations, our rationale for concern is this:

1. Medicaid and Medicare continue to pay hospitals significantly less than the cost of services provided–even by the most efficient providers of care.

2. Medicare Disproportionate Share Hospital (DSH) payments, which were intended as supplemental payments in recognition of significant volumes of underpaid services for low-income individuals and seniors, will be reduced for hospitals by up to 75 percent under the ACA in 2014. Unless these reductions are rescinded or significantly mitigated by Congress, most community safety net hospitals will not be able to provide services to additional patients without full cost reimbursement.

3. ACA Medicaid DSH reductions of up to 50 percent, which begin to take effect in the 2013-14 budget year will exacerbate the funding shortfalls of Essential Community Provider hospitals, further weakening their ability to provide high quality care to their mostly government dependent and charity care patients.

4. The ACA Medicare and Medicaid DSH payment reductions will hit California's private DSH hospitals hardest starting in 2014, when on average each hospital will lose as much as $10 million, and as much as $64 million each from 2014-2019.

5. Essential Community Providers, because of their commitment and geographic location will most likely serve a preponderance of Covered California enrollees that are within the Bridge Plan populations.

6. Plan payments that are between 103-114 percent of Medicare payments will be insufficient to meet plan Administrative costs and provide adequate provider rates.

7. If commercial-like rates do not materialize for the Covered California population, including those under the Bridge Plan proposal, and Essential Community Providers are paid Medicare or Medicaid-like rates instead, California's community safety hospitals will close en masse between 2014-2017 and/or those that can will restrict services.

First, establishing a distinct provider network and negotiating rates for service to the Bridge Plan population which are separate and distinct from existing Medi-Cal contracts must be required of the Bridge Plans to ensure network and Essential Community Provider network adequacy, and we ask the Board to include this requirement in the Bridge Plan certification standards. It is inappropriate for Bridge Plans to be allowed to combine the new Bridge Plan participants and rates with existing Medi-Cal services and negotiated rates.

Currently, the Covered California staff recommendations on Bridge Plans are silent regarding ensuring adequate provider payments. We think this is a serious omission that must be addressed by the Covered California Board.

Secondly, in order for Covered California to meet its goals of ensuring network adequacy, continuity of care and access to traditional providers for these vulnerable populations, Essential Community Providers must be ensured Bridge Plan payments that cover the reasonable costs of services. Failing to do so will not only prevent these goals from being realized but inadvertently contribute to the fiscal insolvency of safety net hospitals and systems throughout California, jeopardizing their ability to care for all residents in their communities. Federal legislators planned that the influx of newly insured Americans under the ACA would ensure stability for Essential Community Providers such as community DSH hospitals. They specifically anticipated that the high volume of newly insured patients through commercial plans with commercial payments–not significantly lower Medicare or Medicaid rates–would eliminate the need for supplemental safety net Medicare DSH and Medicaid DSH hospital payments, which they significantly reduced as part of the ACA.

Giving millions of Californians a Covered California insurance plan will not assure access to care if their hospitals' doors are shuttered. PEACH urges you to take into consideration these indispensable Essential Community Providers in assuring the success of Covered California and in guaranteeing access and continuity of care to low-income Californians when you are contemplating affordability for future enrollees.

II. Covered California Recommendation 2: Bridge Plans Should Cover 138% to 200% of FPL Eligible Population

PEACH agrees with the January 10, 2013 Bridge Plan brief's assertion that "…for families in which the household is between 139% and 250% of FPL, the parents will be eligible for subsidized coverage in Covered California, enrolling in [the] same Medi-Cal Managed Care plan as their children is only an option if that plan became a Qualified Health Plan (QHP) in Covered California," (page 4). This is especially important for the families of the 860,000 children who will transition from the Healthy Families Program into Medi-Cal Managed Care Plans in 2013.

Based on this assertion, it follows that the goals of affordability and continuity of care should be afforded to all low-income families through Bridge Plans offered to those between 138-250% of the FPL eligible population rather than the 138-200% of the FPL as recommended in the staff brief. As discussed above, this expanded Bridge Plan participation level is supported by PEACH only if payments to providers are based on commercial rates rather than underfunded Medicare or Medicaid rates and network adequacy (including Essential Community Providers) has been established.

III. Recommendation 3: Streamlining Approaches for QHP Certification for Medi-Cal Managed Care Plans & Bridge Plans

PEACH understands the desire to streamline the QHP solicitation process to allow all Medi-Cal Managed Care Plans an equal opportunity to respond only to elements of the solicitation that are applicable to a non-commercial health plan.

Given the substantial size of the population in question, and current movement of millions of dual eligibles, SPDs, former Healthy Families Children, and other low-income populations into Medi-Cal Managed Care, efforts should be made to encourage their participation realizing that such expansion by Medi-Cal Managed Care Plans must be done right.

However, regarding the Essential Community Provider Network Requirements, PEACH *does not* support the staff recommendation to "Deem Medi-Cal Managed Care Plans to have satisfied the Essential Community Provider network requirements by virtue of the composition of their typical networks," (page 8).

The current Medi-Cal Managed Care Plans' hospital and physician networks may not be sufficient in all regions of the state and, as discussed above, Essential Community Providers may have to forgo participation if rates offered are unsustainable and/or would result in reduction of other patient services in order to participate. For these reasons, PEACH recommends that the Medi-Cal Managed Care Plans bidding to become Bridge Plans be held to the same Essential Community Provider Network adequacy standards and certification as other QHPs in the Exchange.

IV. State Medicaid Expansion Considerations–State Option vs. County Option

While Covered California may be able to quickly address the above concerns, we believe the Governor's January 10, 2013 Budget, which proposes exploring both a state-based ACA Medicaid expansion option and an alternative county-based Medicaid expansion option to manage the newly eligible Medi-Cal population, requires thoughtful consideration before Covered California adopts any Bridge Plan proposals.

As we understand from Administration accounts, the Governor believes this issue must be carefully considered in the coming months before a decision is made. We believe it is imperative that Covered California has the opportunity to fully consider how a potential county-based expansion option would intersect with Covered California's efforts to establish effective Bridge Plans. For example, could the county Medicaid expansion option result in county operated or majority county controlled plans being given near-monopolistic control and elimination of choice for low-income Californians up to 200-250 percent of FPL if Covered California instituted its Bridge Plan program? Does the Covered California Bridge Plan concept result in exacerbating real or perceived Medi-Cal Managed Care Plan and county system market advantage at the expense of healthy competition and quality advances? Would Essential Community Providers lose all negotiating strength and be forced to accept inadequate rates and standards offered by Medi-Cal Managed Care Plans in order to serve their communities?

We believe now is the time to form a safe and easily navigable crosswalk for transitioning low-income Californians between Uninsured/Medi-Cal/SCHIP/Covered California and with all programs being considered and developed concurrently. Creation of the Bridge Plans in the coming weeks seems to be on an expedited path that is now out of sync with the Governor's timeline on creating a state or county controlled Medi-Cal system for the nearly 2 million newly eligible Medi-Cal beneficiaries in 2014.

Consequently, with the Governor's concept released just late last week, we must reluctantly but emphatically ask that you refrain from implementing any Bridge Plan policies until it can be explained, among other issues, how the newly eligible Medi-Cal population will be guaranteed choice and access to high quality care in a county-based expansion option and when transitioning from a county-based expansion option to a Healthy Families level of coverage and/or to a Bridge Plan in Covered California. As Covered California has correctly concluded, affordable and high quality coverage choices for low-income Californians are essential. The issues that arise from a new county-based Medicaid option must be considered by Covered California as you develop the framework for the Bridge Plans.

Thank you very much for your consideration of our comments and recommendations. PEACH looks forward to continuing to work with Covered California as it determines how to best maximize affordability, access and continuity of care in the exchange. Please feel free to contact me at 916-446-6000 should you have any questions.

Sincerely,

Catherine K. Douglas
President and CEO

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